CIS PowerChart/ CareConnect Manual for Nursing Services

Sequoia Hospital
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Redwood City, CA 94062

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The information in this document is accurate as of its publication date. While a conscientious effort was made to avoid errors, some may still exist. Please report any errors to the name listed below. The information in this document is subject to change without notice.

September 2011
Sequoia Hospital Clinical Informatics Department

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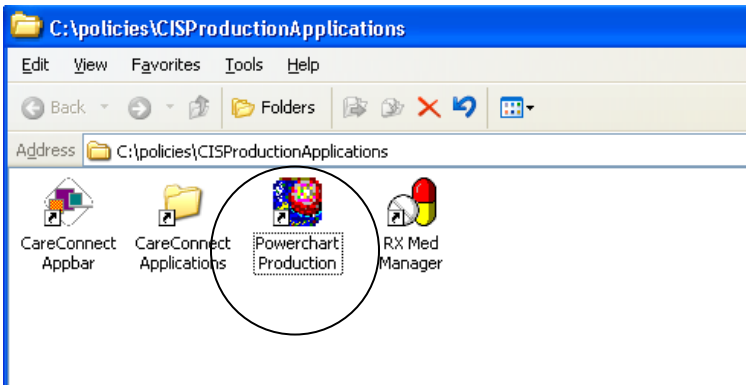
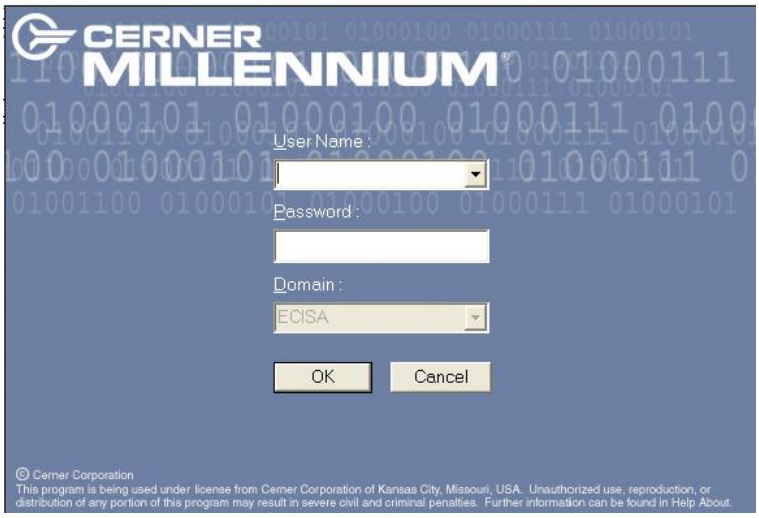
ACCESSING CIS POWERCHART

1. Double click the **PowerChart icon** (label: CIS Desktop Production) located on your desktop or clinical tunnel menu to launch the application.

2. Double click **PowerChart Production**



3. The Cerner Millennium log on window displays.


CERNER MILLENNIUM
User Name :
Password :
Domain :
CISA
OK
Cancel
© Cerner Corporation
This program is being used under license from Cerner Corporation of Kansas City, Missouri, USA. Unauthorized use, reproduction, or distribution of any portion of this program may result in severe civil and criminal penalties. Further information can be found in Help About.

4. Enter your **CareConnect Username and Password**. Click **OK**.

After logging into CIS CareConnect, notice that the Patient List and Patient Access List (PAL) are now on the toolbar. The following positions will have the PAL as their default when they sign in CIS Care Connect, otherwise, you will open up to the Patient List: Nursing (RN/LVN), Case Management, Diabetic Clinic, Pharmacy and Rehab Services.

To learn more about the PAL, turn to page: 8

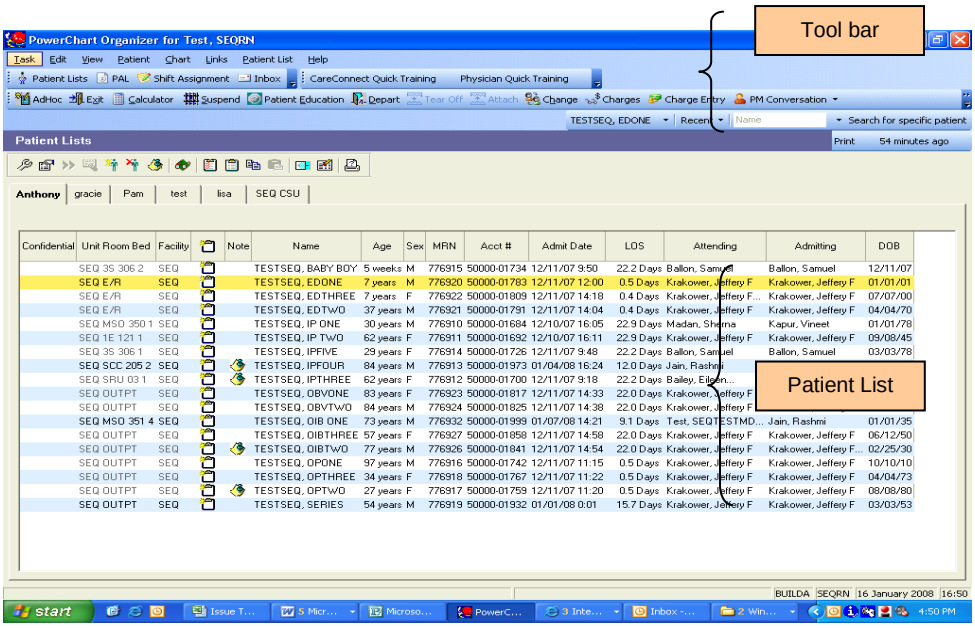
DID YOU KNOW

You can access CIS PowerChart outside the hospital. To do this, follow the instructions in the "Remote Access" instruction in your New Hire Packet.

ORGANIZER BASICS

The two main parts of PowerChart are:

a. **Organizer**: similar a chart rack holding multiple medical records
b. **Individual Patient Medical Record**: represents single patient charts



The Organizer is made up of the tool bar, Patient Access List or the Patient List.

DEFINITIONS

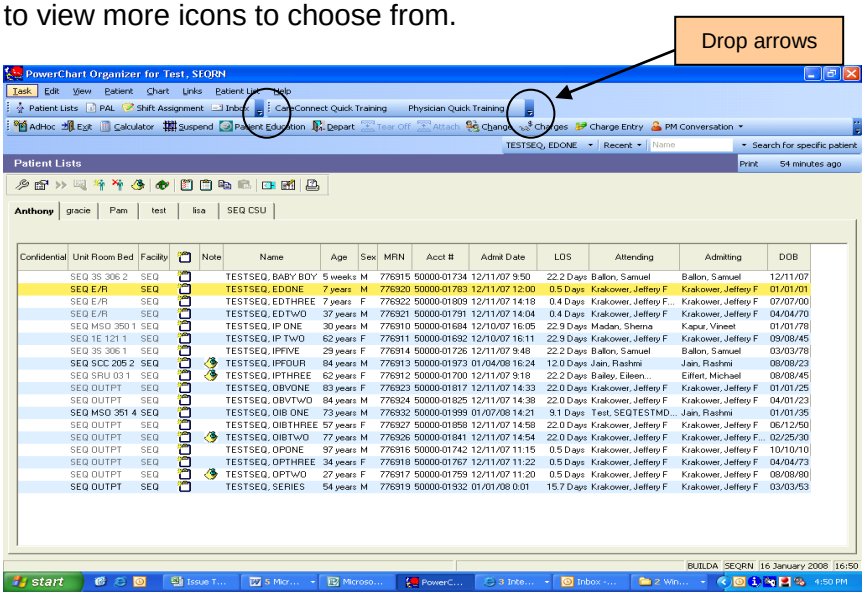
A **tool bar** is a series of selectable buttons in CIS usually located in the top screen that gives you an easy way to select a function within CIS CareConnect.

TOOLBAR

1. Icons are **labeled** with names. For example,

shows the label: Adhoc. There's no guessing on what that icon is!
Note: Not all icons that you see in the toolbar are used at this time.

2. To view more icons that are not visible in the tool bar, click the **down arrow** at the end of tool bar. Once you click this, you will now be able to view more icons to choose from.



DID YOU KNOW

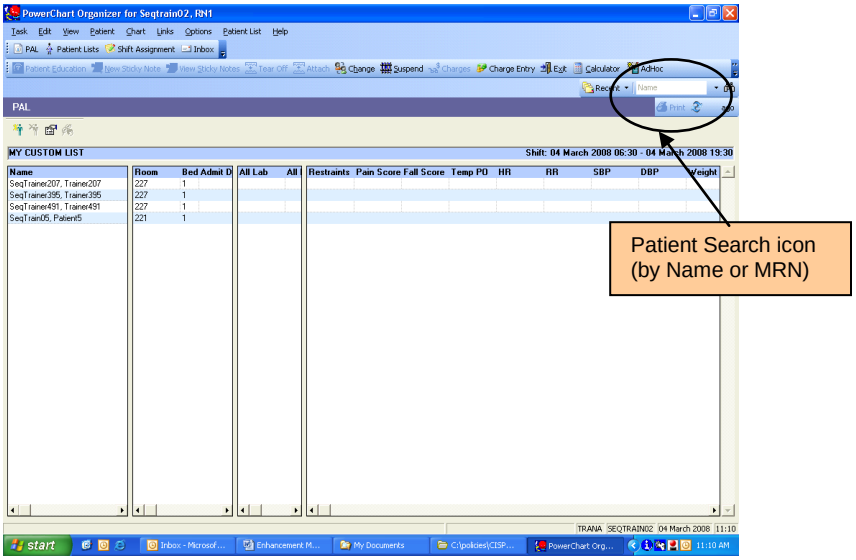
You can customize your tool bar so you can have the icons you use most in front of you? To do this, turn to page 45 for instructions!

3. **Change icon** – The Change Icon allows you to change from one user to another (such as from nurse to physician if need be). When the new user logs in, they will be logged in the same place the previous user left off.

DID YOU KNOW

You can search quickly by MRN by clicking the drop down arrow next to "Name field" and select MRN.

4. **Patient Search**. To search for a patient, type in the patient's name in the Name field and press the enter key on your keyboard. The "Patient Search" window opens. Select the correct patient and encounter.



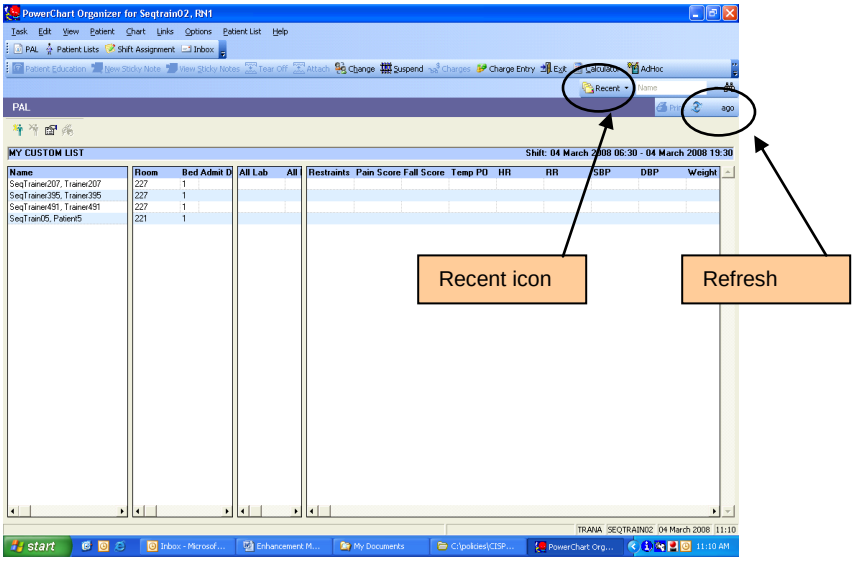
5. **Recent icon**: To find a patient's chart that had been opened recently, click the down arrow next to Recent. This icon will show up to 5 patient's charts that have been opened.

6. **Refresh button**. To refresh, click the "refresh" button next to the print button. It will display number of minutes since last refresh, rather than displaying the time. Notice that it will set at zero every time your hit refresh.

DID YOU KNOW

The refresh button is at the same location on the patient's chart (far right end of tool bar).

7. **Print icon.** Select printer from the list to print reports such as your daily census.



You can print your daily census report as easy 1-2-3.

1. Go to the patient's list
2. Hit the print icon
3. Select your printer

8. **Patient Education icon**

and **Depart icon**

- Patient education handouts are available in CIS CareConnect. The depart icon opens a new section that focuses on documentation related to the patient's discharge.

9. **Quick Training Icons**

Links to the Care Connect Training Website can be accessed through CIS Care Connect. Simply click the icon "CareConnect Quick Training" and this will take you to the online guide/user manual if you want need extra help!

PATIENT ACCESS LIST (PAL)

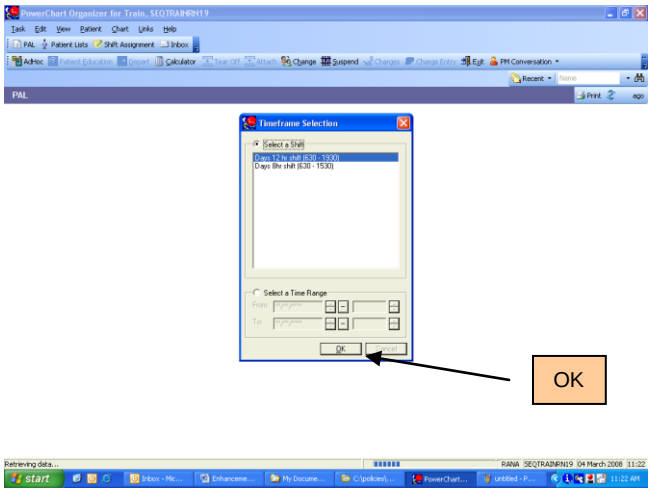
DID YOU KNOW

(If you are a nurse, works in Case Management, Diabetic Clinic, Pastoral Services, Pharmacy and Rehabilitation Services, PAL will be your default when you sign in to PowerChart. You do not need to click PAL if that's the case)

Patient Access List (PAL) helps clinicians work effectively and efficiently by providing key patient and workflow information in an easy-to-access format.

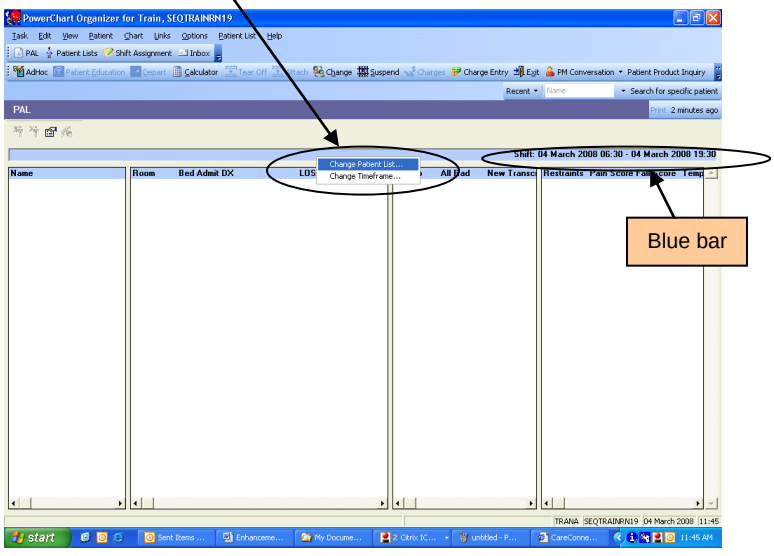
To access the PAL complete the following steps:

1. Log on to PowerChart
2. Click **"Patient Access List" (PAL)** icon.
3. **Timeframe Selection**:
   c. Click on one of the options available and click **OK**. Example: Days 8hr Shift (630-1530)



To associate your PAL with your Patient List complete the following steps:

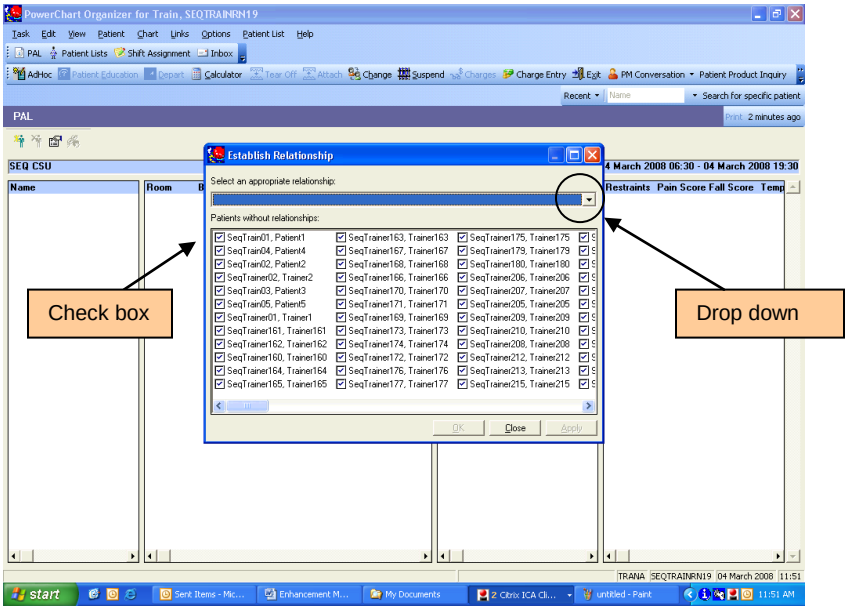
1. Right click on the **blue bar** (where it says "Shift...")
2. Select "**Change Patient List**"



3. Select the **Patient List** you want to see on your PAL, for example, your own **customized list** or your **department census list** (SEQ MSO).
4. **Establish a Relationship**. You will only do this the first time and

anytime a new patient is added to your PAL.

Click the drop down arrow in the "**Select an appropriate relationship**" box to select a relationship type from the list. If you are a nurse, select "Primary/Staff RN". Click **OK**.



5. All the patients in that are listed in the "patient list" you selected will now show up in your PAL.
6. To **change the PAL to a different patient list**, simply **follow steps#1-5.**

DID YOU KNOW

You can select or deselect patients you want or do not want to establish relationship by clicking the check box before the patient's name.

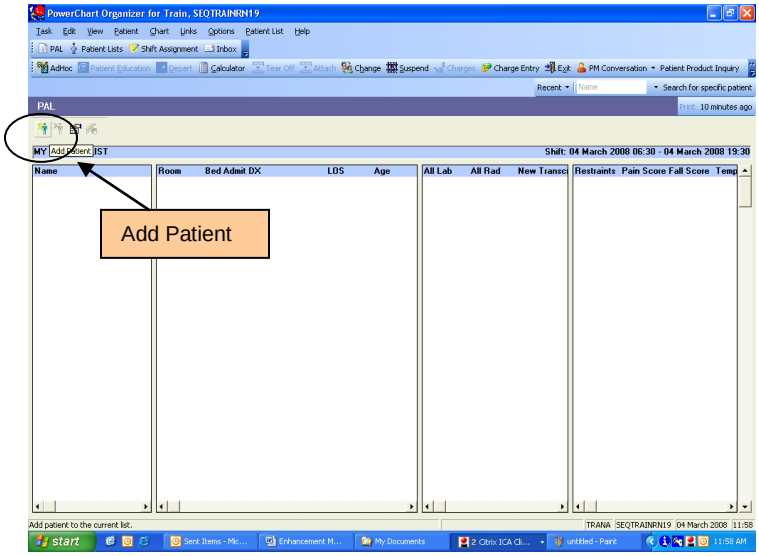
ESTABLISHING RELATIONSHIP

You should not add patients to the list you do not need data on unless you are a Charge Nurse.

If you don't associate yourself, display will say "No Relationship". To see data, select patient and you will be prompted to establish your relationship.

To manually add patients to your complete the following steps:

1. From the PAL, click the "**Add Patient**" icon located in the left side of the screen. (The icon looks like a green man with a yellow ray).



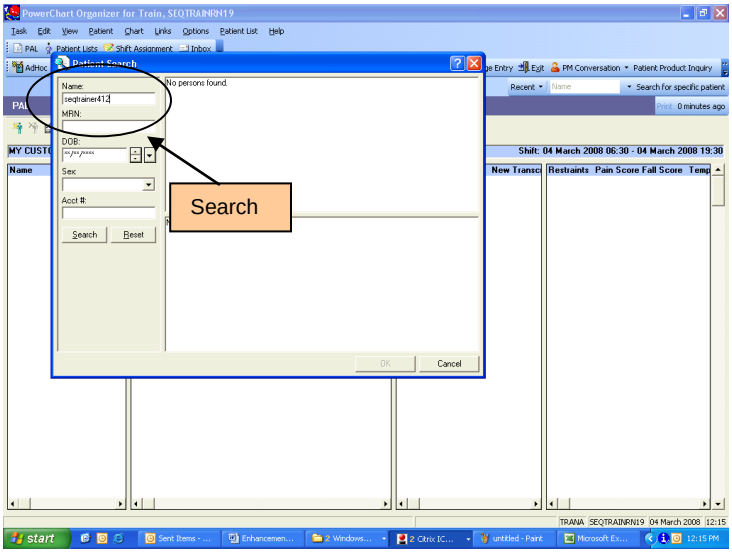
DID YOU KNOW

Your patient list and your PAL communicate. If you add a patient in the PAL, that will update your patient list, and vice-versa!

2. The "**Patient Search**" window appears. Type in the **patient's name**

or **Medical Record#** or **Account #** to search for the patient.

3. Click **OK**



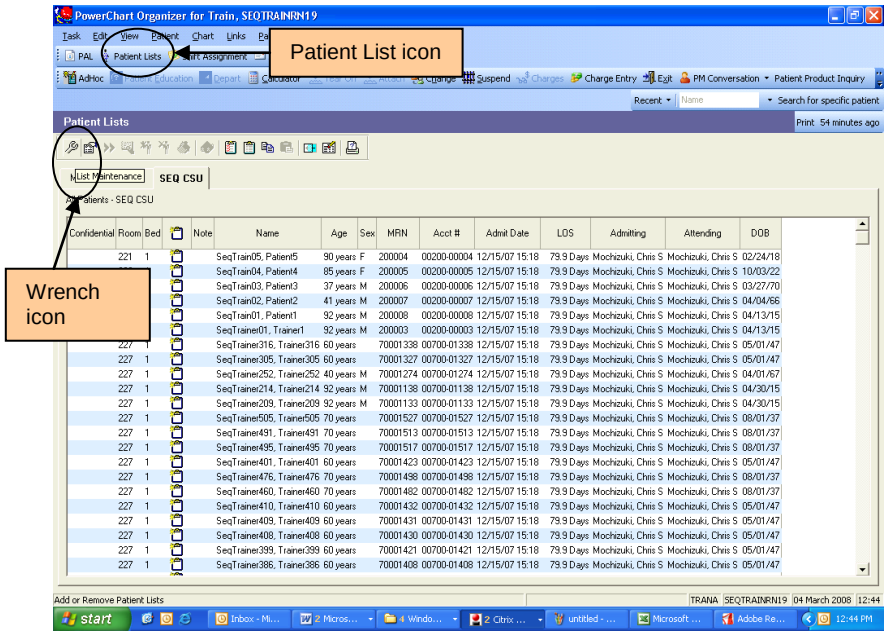
4. After you click **OK**, it will add that patient to your **patient list.**

PATIENT LIST

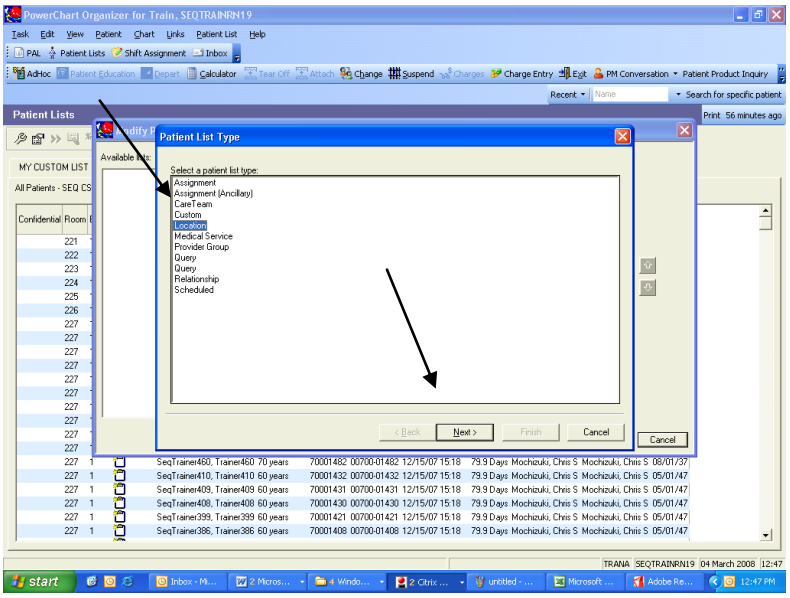
The patient list is where you can have your patients listed by location (CSU, MSO, ICU, MHU, AMU, etc), provider group or by your own custom list.

To create your location list, e.g, specific department or unit, complete the following steps:

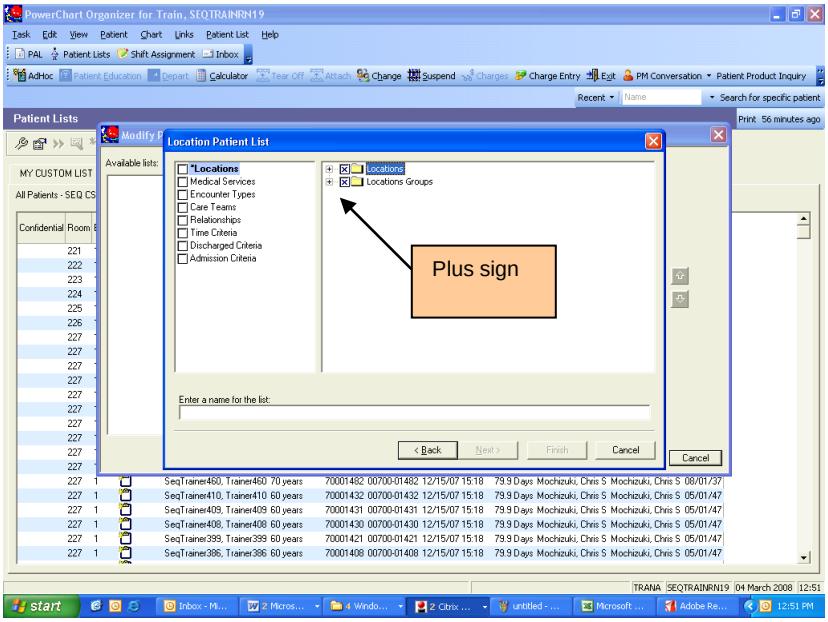
1. Click the “Patient List” icon in the toolbar.
2. Click the wrench icon in the toolbar below “patient list” bar.



3. Click the **New** button on the bottom of the window
4. "Patient List Type" window displays.
5. Select "**Location**" and click **Next**



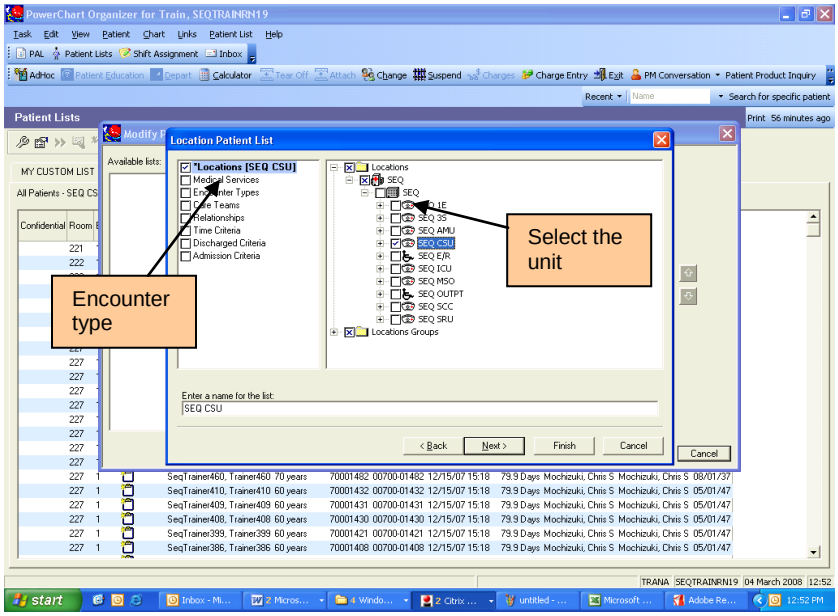
6. "Location Patient List" window displays.
7. Click the "**plus(+) sign** next to the folder **Locations**.
8. Click the "**plus(+)** sign next to **SEQ**
9. Click the "**plus(+)** sign next to **SEQ** again.



10. Select the **unit** you want by click **the check box** next to it.

TIP

Do not select multiple units all at the same time. Maintain each unit as a separate location list so you have separate tabs in the Patent List window!



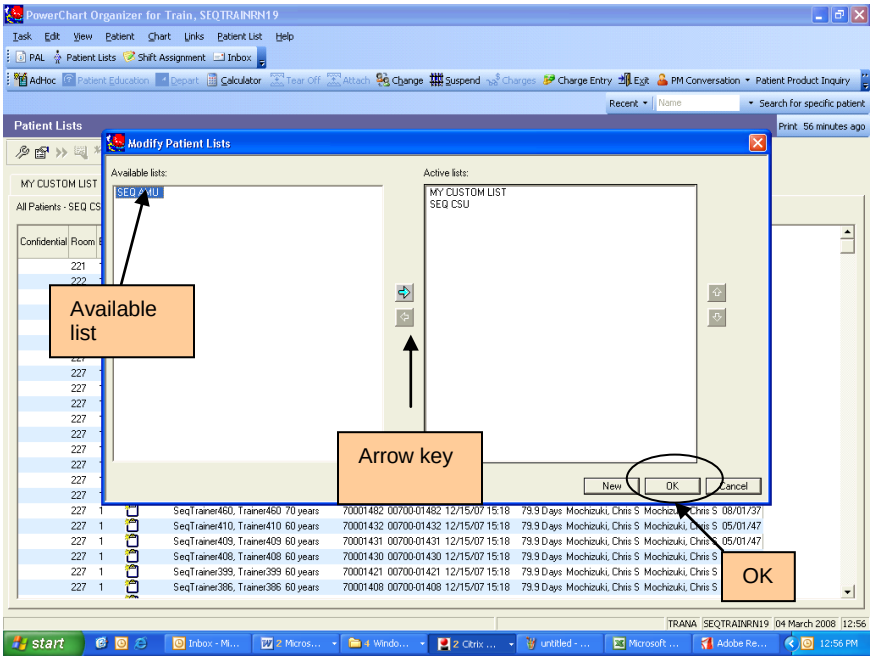
TIP

For inpatient locations, choose Inpatient, Observation and ED patient only. Do not choose OP.

11. Click **Encounter Types box**. Select appropriate encounter types, e.g., Emergency, Inpatient, Inpt Preadmit, Observation, Outpatient, etc.
12. Click Finish.
13. The unit you selected will now display in the Available list (left side of the screen).

To move that unit to your Active list, complete the following:

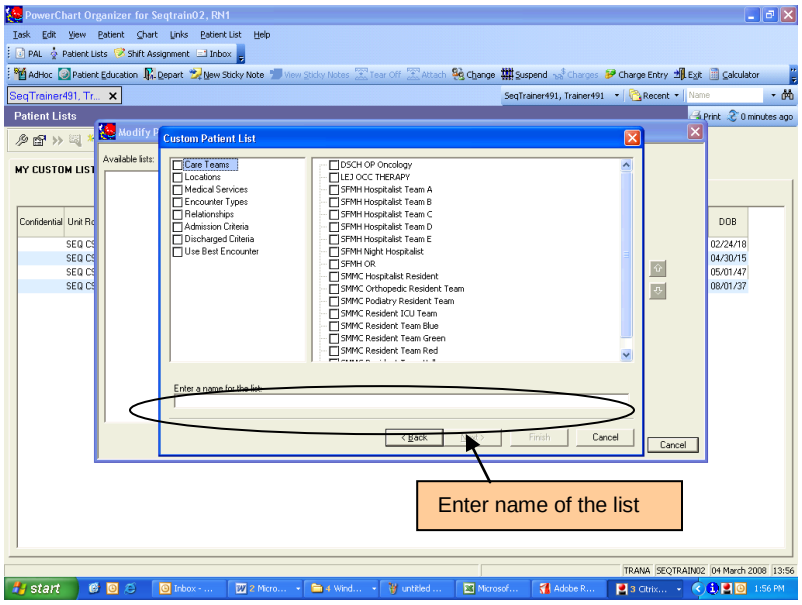
14. Click the **unit** you want to move
15. Click the **blue arrow key**
16. Click **OK**



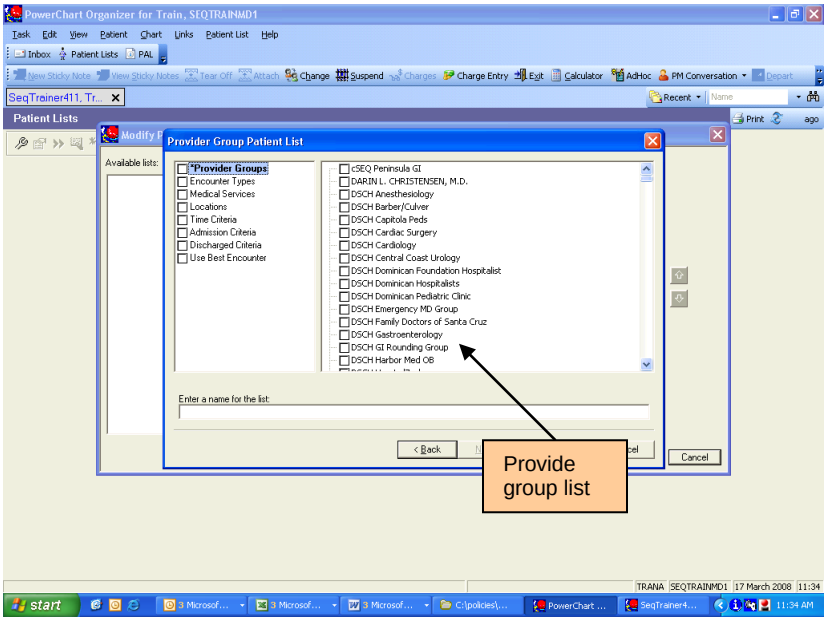
To **add another unit**, repeat **steps 1 to 16**.

Creating a Custom List

1. Click the **wrench** icon in the toolbar below “patient list” bar.
2. Click the **New** button on the bottom of the window
3. “Patient List Type” window displays.
4. Select “**Custom**” and click **Next**
5. “Custom Patient List” window displays. Enter a name for the list in the bottom of the screen.



6. Click **Next**.
7. Keep the filter defaults to “None”, select **Next**
8. Move the list from the “Available lists” to the “Active lists” and click **OK (Follow steps #14 – 16 above)**.
9. “My Custom List” tab displays on the “Organizer



1. Click **Finish**
2. Use the **move** button to move your list from the available list to the active list window.
3. Click **OK**

PRINTING ROUNDING REPORTS

DID YOU KNOW

MD Rounding reports are printed prior to a Planned Downtime (CIS not available) event.

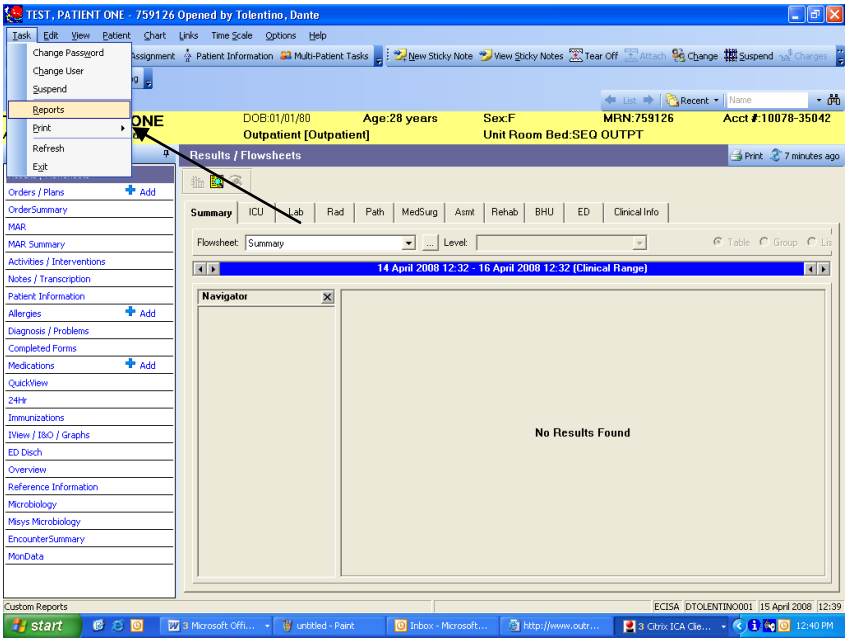
DID YOU KNOW

To print a paitent census summary, complete the following:

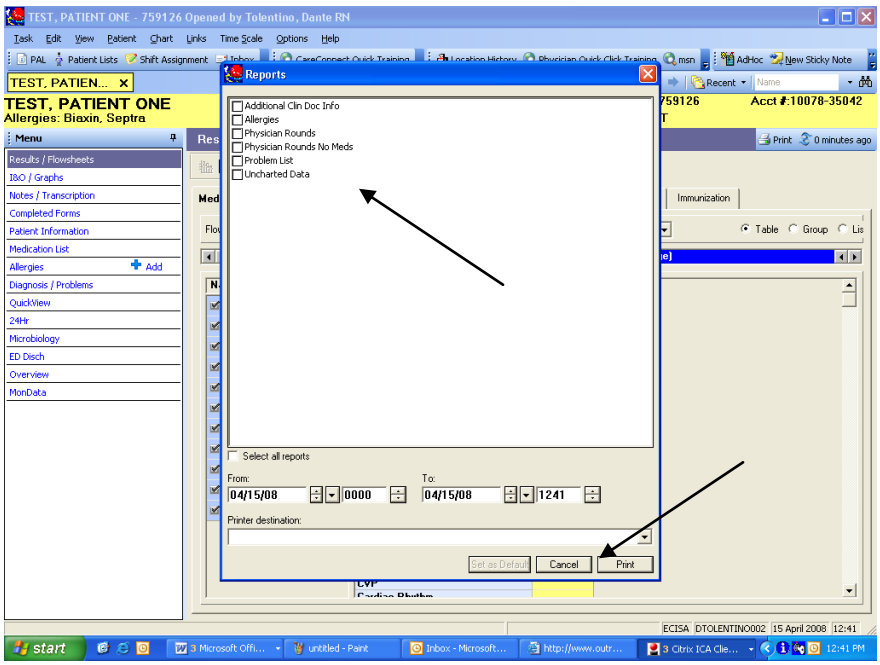
1. Go to Patient List
2. Click the Unit you want to print census.
3. Click the Printer Icon (below the patient banner)
4. Select the printer
5. Click OK

To print a MD Rounding Report, complete the following steps:

1. Open a **patient chart**
2. Click "**Task**" on the menu bar
3. Click "**Reports**"


TEST, PATIENT ONE - 759126 Opened by Tolentino, Dante
Task Edit View Patient Chart Links Time Scale Options Help
Change Password
Change User
Suspend
Reports
Print
Refresh
Exit
DOB:01/01/80 Age:28 years Sex:F MRN:759126 Acct #:10078-35042
Outpatient [Outpatient] Unit Room Bed:SEQ OUTPT
Results / Flowsheets
Summary ICU Lab Rad Path MedSurg Asmt Rehab BHU ED Clinical Info
14 April 2008 12:32 - 16 April 2008 12:32 (Clinical Range)
Navigator
No Results Found

4. Click the **box** located to the left of "**Physician Reports No Meds**"
5. Select a **printer** under printer destination (if no printer is selected)
6. Click "**Print**"



PATIENT CHART OVERVIEW

You can access patient chart from the Patient List and/or the Patient Access List. Either way to open patient chart complete the following steps:

a. Double-click the desired patient record on either the PAL or Patient List
OR
b. Searching a patient in the “Name field”.

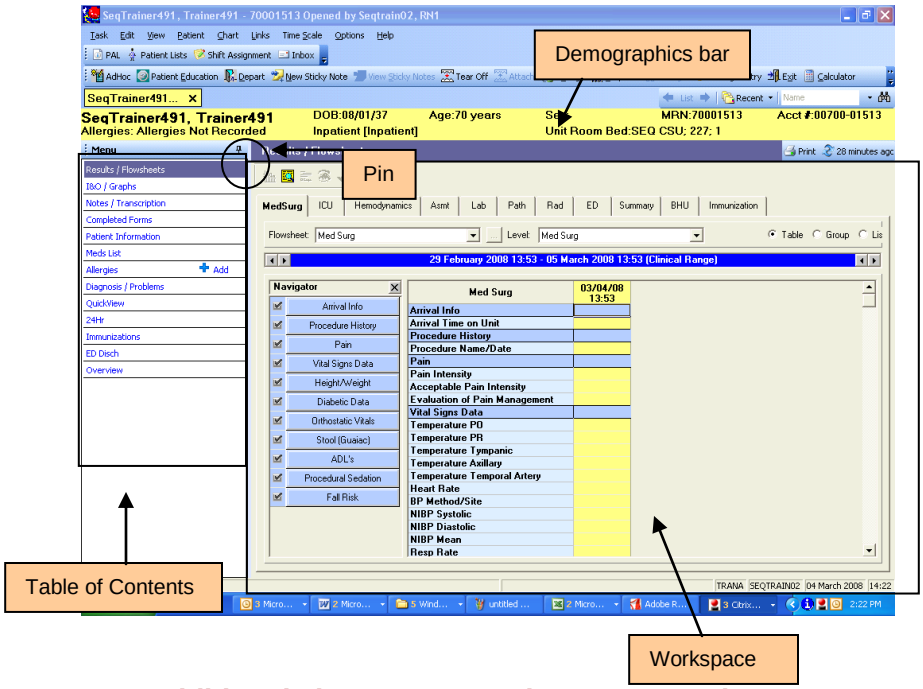
Demographic Bar

The demographic bar is the colored band at the top of the patient’s chart. It contains the patient’s demographic information, such as name, age, sex, MRN, account#, unit room number and patient type.

Patient chart view is made up of two panes:

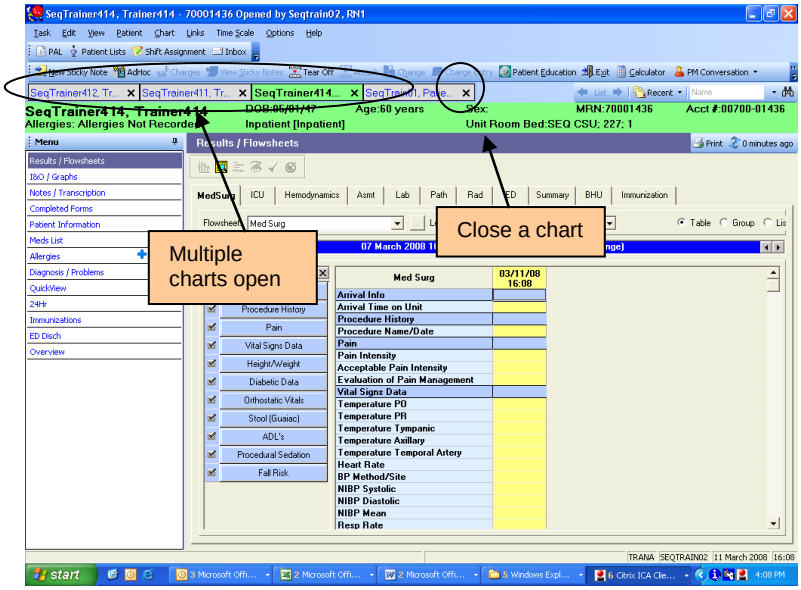
1. **Table of Contents** – displays on the left side of the screen. It is a way to quickly navigate the patient’s chart.

2. **Workspace** – displays on the right side of the window. This screen changes based on the menu item you selected from the table of contents.



To open additional charts. You can have up to 4 charts open simultaneously.

If you want to open additional charts without closing the one you currently have open, complete the following steps:
1. Search for a new patient or
2. Select the patient from the “Recent” icon list.



Note: To **close** a chart from your view, simply click the (**X**) next to the patient name's tab.

The following bands in the Table of Contents are currently being used at Sequoia Hospital:

1. Results/Flowsheets
2. I&O/Graphs – for select units
3. Notes/Transcription
4. Completed Forms
5. Patient Information
6. QuickView
7. 24Hr
8. Overview

What's stays on paper

1. Allergies – gold standard for allergies is your Medication Reconciliation
2. MAR
3. Nursing Plan of Care
4. I&O – for select units
5. ED
6. Medication Reconciliation
7. Discharge Instructions

DID YOU KNOW

You can hide the table of contents in order to maximize your workspace area!

To hide it:

1. Click on the pin icon
2. The Table of contents will slide to the left of the screen.

To unhide it:

1. Hover on the word "Menu"
2. Click the pin icon again.

DID YOU KNOW

When you open multiple charts, each demographic banner will have their own distinct color!

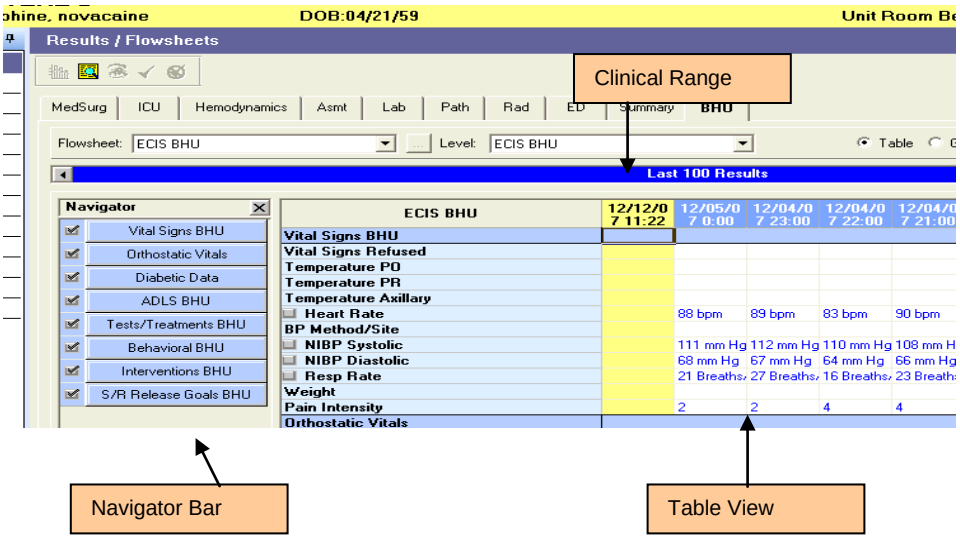
RESULTS/FLOWSHEETS

Click **"Results/Flowsheets"** section on the Table of Contents to access the following flowsheets:

- **MedSurg:** displays numeric clinical values imputed on either nursing forms or directly charted on the flowsheet.
- **ICU:** Used in ICU that document in CIS. Displays numeric clinical values that is either inputed on nursing forms or directly charted on the flowsheet. Vitals from monitors are pulled into this flowsheet.
- **Hemodynamics:** displays hemodynamic vitals, output and input data
- **Asmt:** displays textural values imputed on either nursing forms or directly charted on the flowsheet
- **Lab:** displays lab results (numeric)
- **Path:** displays Pathology reports (dictated)
- **Rad:** displays Radiology reports (dictated)
- **ED:** displays ED nursing data
- **Summary:** displays select results such as vital signs, lab results, nursing assessment
- **BHU:** displays clinical values specific to Mental Health Unit
- **Immunization:** displays documented immunization, inoculations or vaccinations given to the patient
- **Micro:** displays microbiology results

Flow sheets Layout

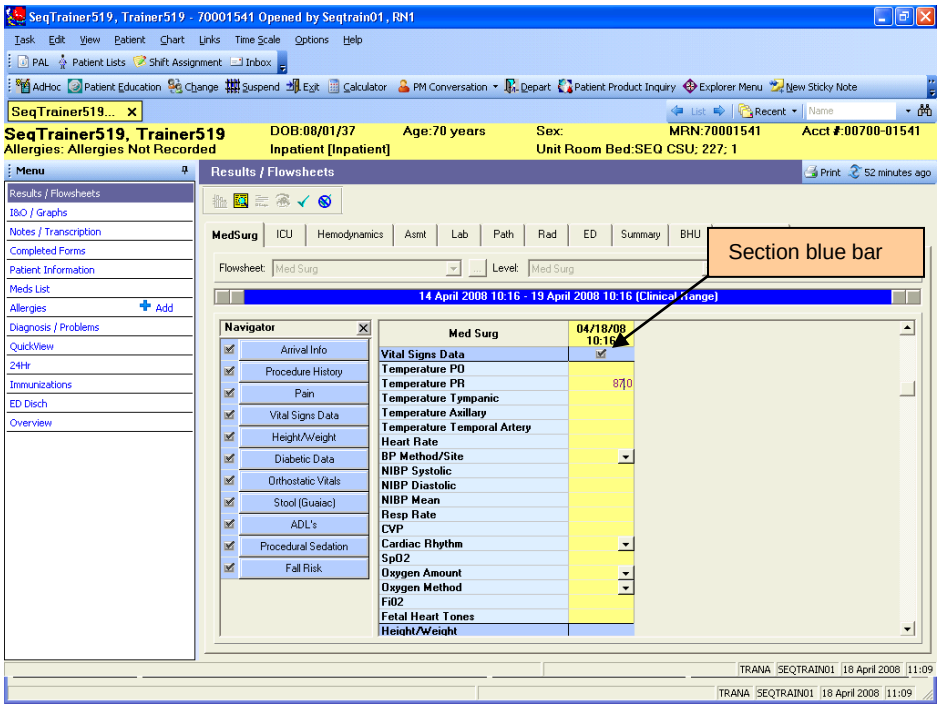
- **Blue Clinical Range Bar-** used to specify time frame for data display.
- **Navigator Bar to the left of the screen-** Lists the sections that are available for display
- **Table View-** made of intersecting rows and columns that forms cells where data are entered: used to display discrete



Direct Charting on Flowsheets

Displays numeric or text clinical data entered either directly on the flowsheet or auto-populated from nursing forms and laboratory results. The MedSurg flowsheet sections are highlighted in blue. To document on a section you need to complete the following steps:

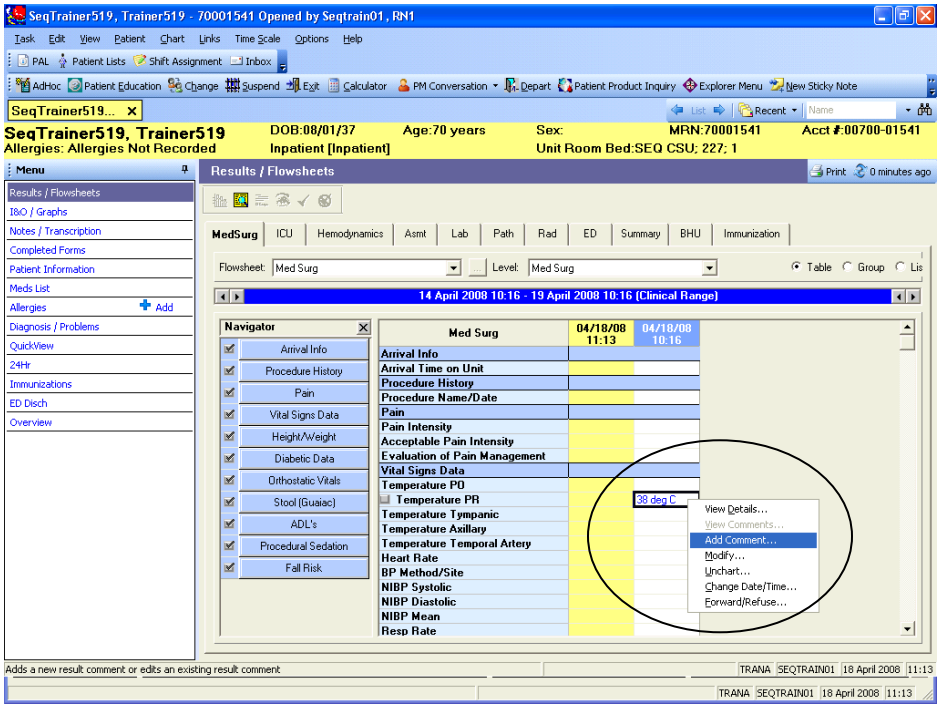
1. **Double**-click the section blue bar to activate the selected section's cells
2. Click or use the keyboard down arrow key to place your cursor in the cell
3. Enter the desired data
4. Continue until you are done charting
5. Click the **Sign** icon on the toolbar to save your documentation
6. Click the **Refresh** icon to refresh your view



Add or View a Comment

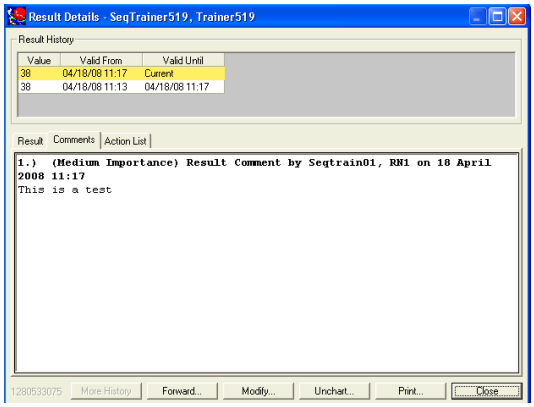
Add a Comment

1. **Right**-click the charted cell and select “Add a Comment”. The Result Comments window displays.
2. Enter the desired text and Click **OK**. The cell displays a * to the right of the data.



View a Comment

1. **Right**-click on the same cell and select “View Comment”.
2. When done click **Close**



Modify Charted Results- Outside Range Value

1. **Right**-click the charted result
2. Select “Modify”. The “Result Modification” window displays. Enter a different value in the flashing blue box.
3. Click **OK**. If you have charted a value outside the feasible range, a “Charting Warning” text box displays. Click **Yes** and **OK**
4. Enter a comment and click **OK**
5. Click **OK** to the second warning. The flowsheet displays the outside range value in **Red Color**

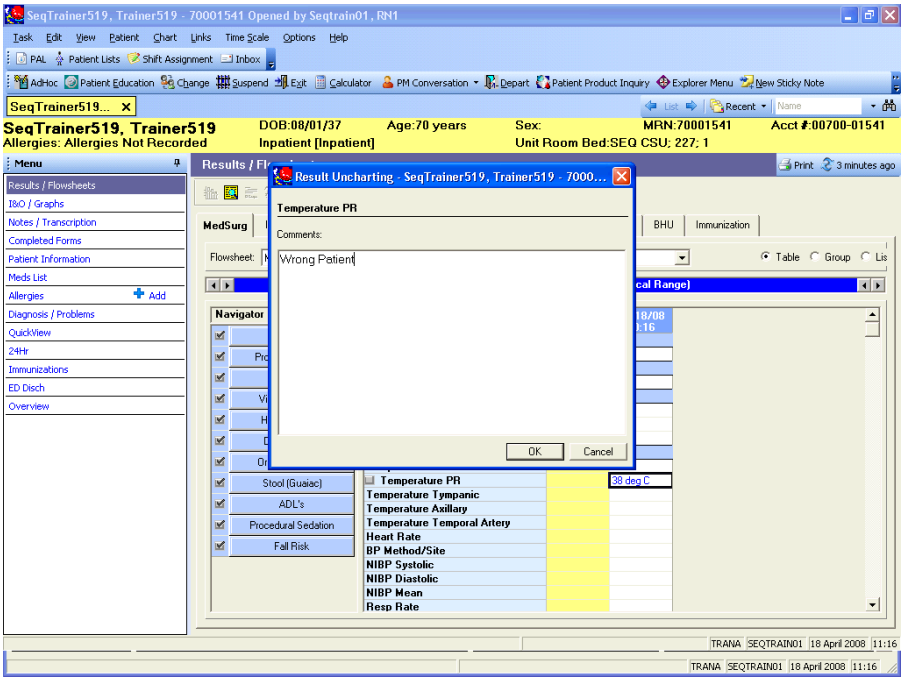
“Unchart” Erroneous Data

Sometimes you may enter data on the wrong patient and you will want to unchart that data.

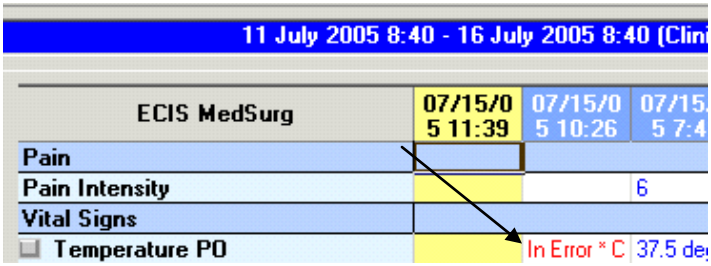
1. **Right**-click the charted data
2. Select “Unchart”. Enter a comment.
3. Type in the reasons for charting such as “Wrong Patient”. Click **OK**.

TIP

You cannot delete data from CIS. You can only modify or “unchart”.

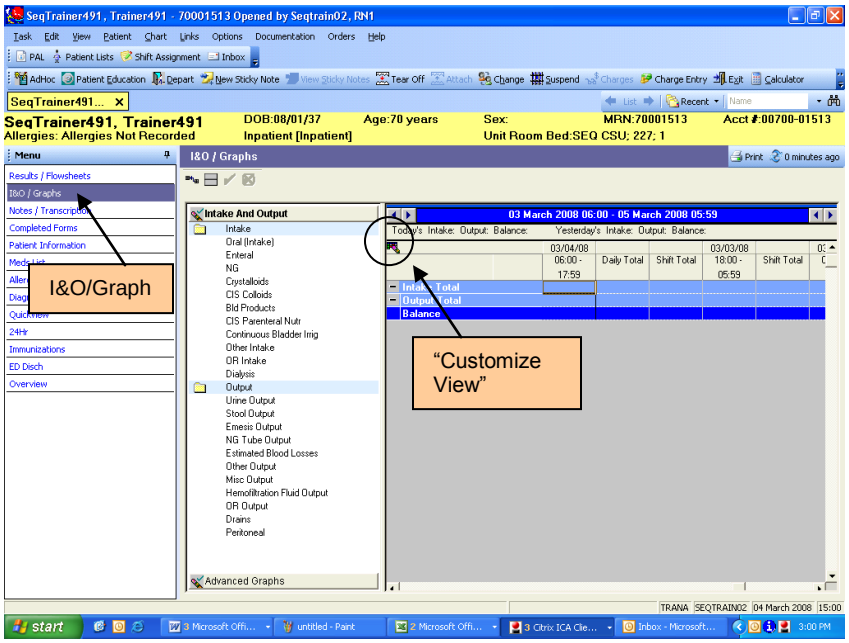


The flowsheet displays “In Error”.



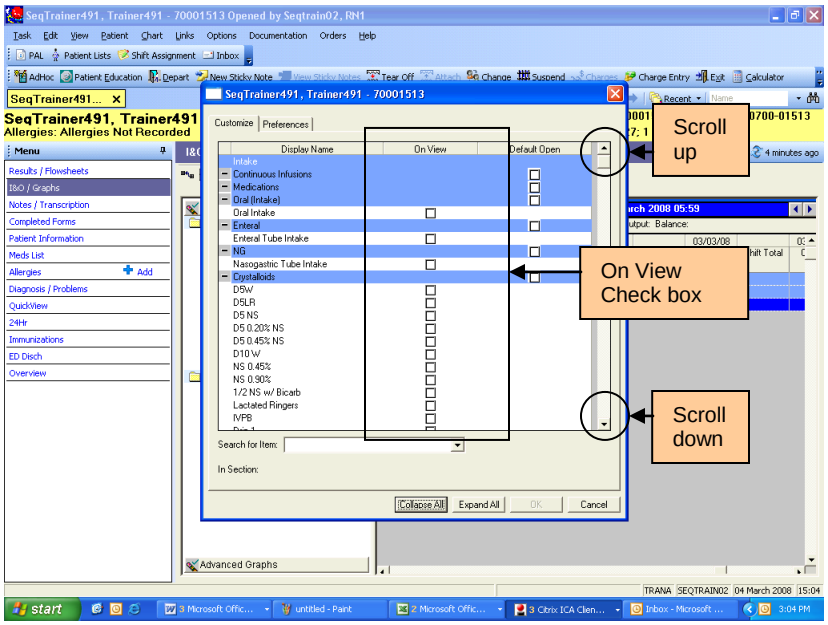
INTAKE AND OUTPUT (I&O)/ GRAPHS

To access **I&O**, select I&O/Graphs from the **Table of Contents**



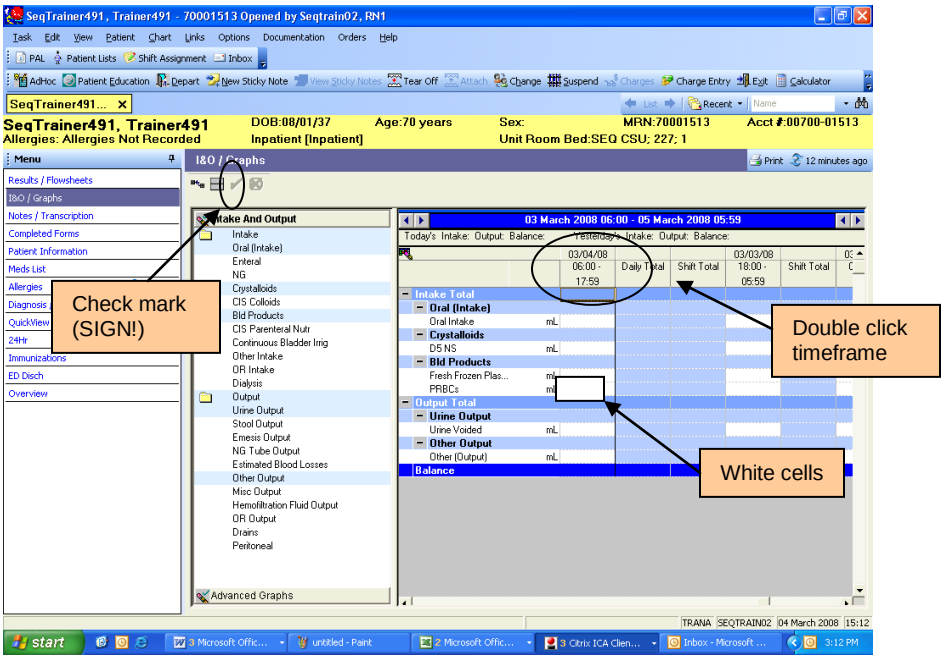
To enter Intake and Output, complete the following steps:

1. Single click the "**Customize View**" Icon located below the blue time range
2. Single click the desired **categories** under the "**On View**" section (e.g. Oral Intake, IVPB). Scroll down to see other categories.



3. When done, click **OK**.
4. This will build your I&O form.

5. **Double click** the **time-range/timeframe** to activate the cells (e.g., 0600 – 0659) located just below the blue bar . You can also double click the blue bar specific to the category that you want to chart on.



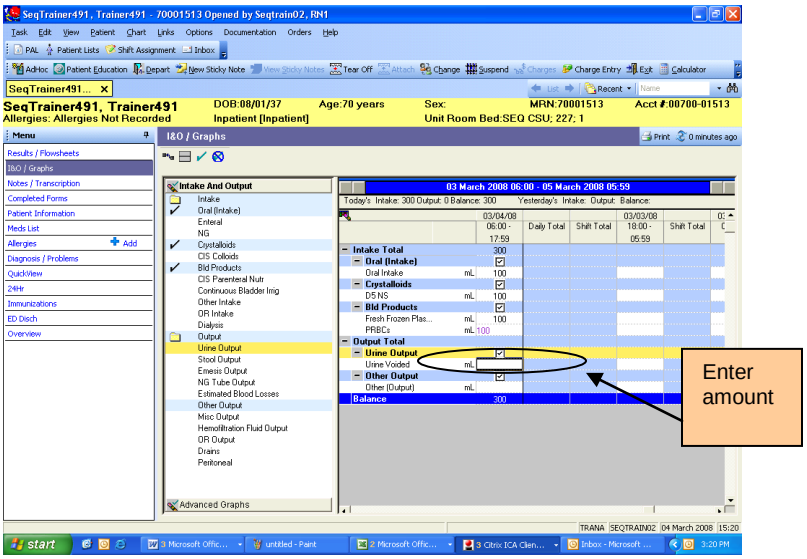
6. Click **cell** to enter data. Type in your data.
7. When done, hit enter and then click the **green check mark**.
8. Data are now entered in I&O and color changes from purple to black.

To add values within the same timeframe, complete the following:

1. Double click the **timerange/timeframe** you want to add values to.
2. **Click** the **cell** you want to add (once you click that cell will be blank even if you already charted on it).
3. **Enter** the desired amount
4. Hit **enter from your keyboard**
5. Click **Sign**

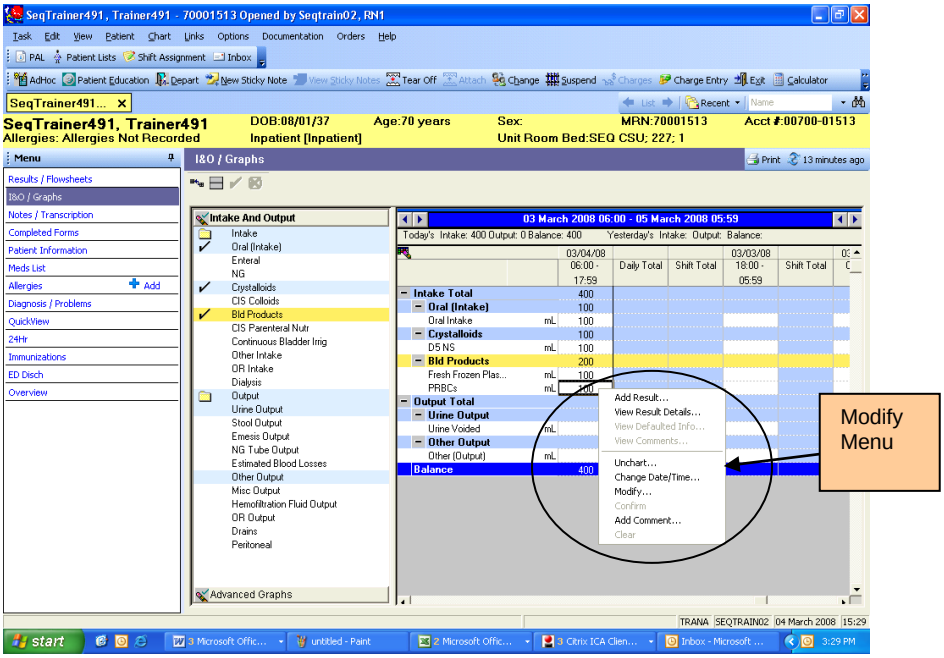
DID YOU KNOW

The total displayed is the sum of all values entered for that time period!

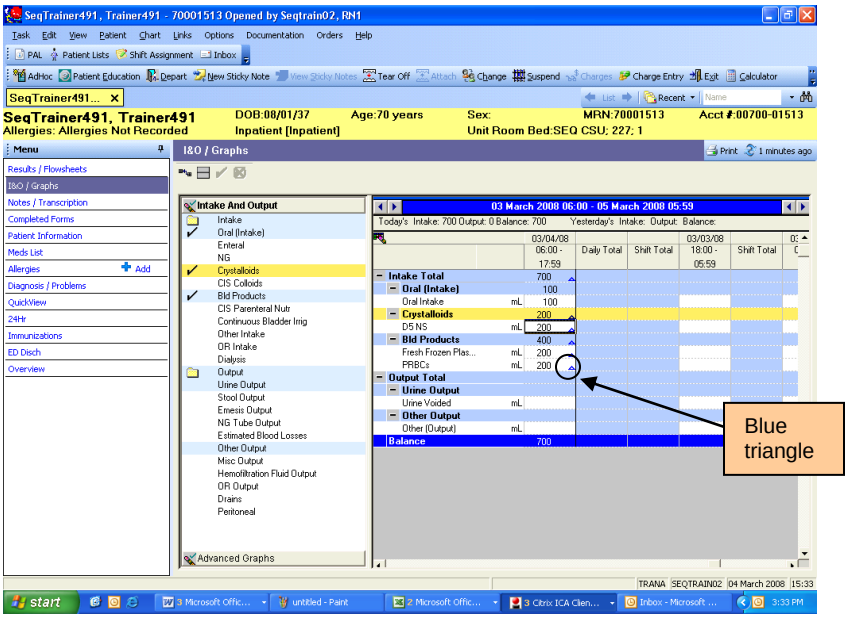


To modify I&O you already entered, complete the following steps:

1. **Right click the value you want to modify**. Remember to right click on the **white cell** and not on any other color.
2. Select **Modify** from the menu

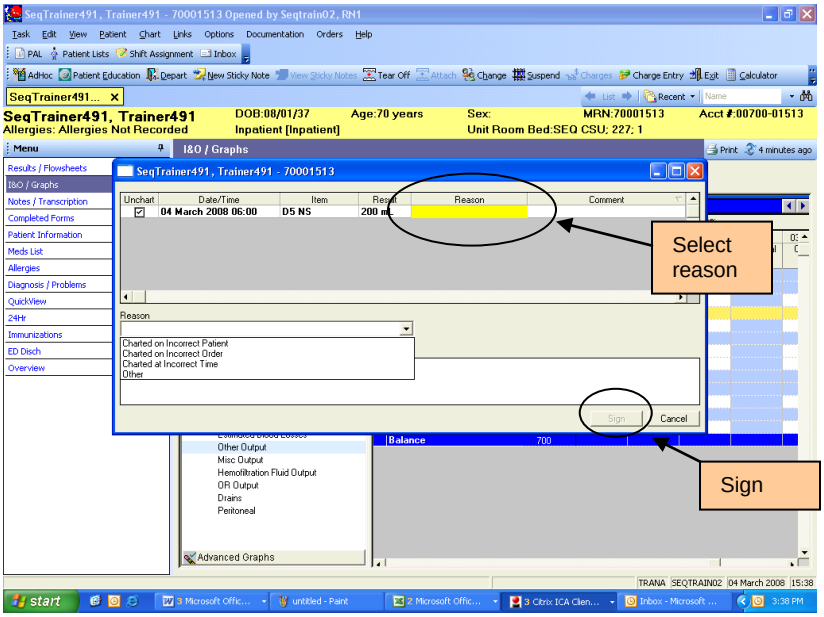


3. **Delete** the current value you want to modify by hitting the delete key on backspace key from your keyboard.
4. **Enter** the correct amount.
5. **Sign** by clicking the **green check mark**.
6. Notice that after you sign, the cells you corrected will have a **blue triangle** at the bottom-right side of the screen signifying that value was corrected.



To unchart I&O, complete the following steps:

1. **Right click the value you want to unchart**. Remember to right click on the **white cell** and not on any other color.
2. Select **Unchart** from the menu
3. From the screen, select the reason why you want to unchart. Do this by clicking the **yellow** box under “Reason”.
4. Select the **reason** for uncharting – incorrect patient, incorrect order, incorrect time or other.

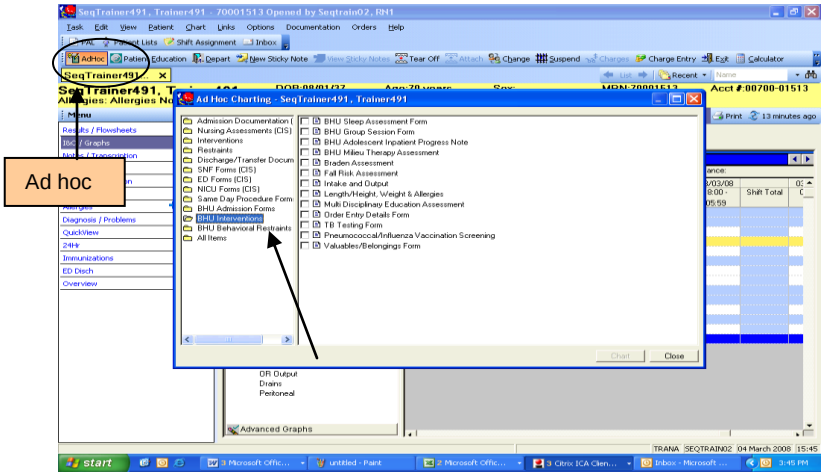


5. Click **Sign**.
6. Note in the I&O flowsheet, the cell will display “In Err” signifying that you uncharted that value.

FOR BHU STAFF ONLY

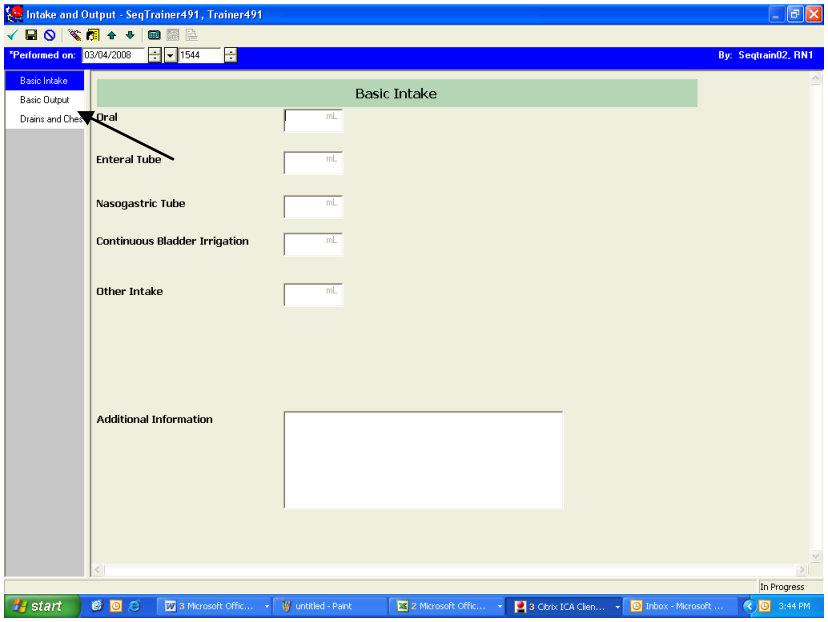
<u>To enter your I&O, please complete the following steps</u>:

1. Click “**Ad-hoc**” from the toolbar
2. Click **BHU Interventions**



3. Select **Intake and Output**
4. Click **Chart**

5. Enter your **intake** values
6. Select "**Basic Output**" from the left side menu
7. Enter you **output** values
8. Click **sign**



To modify or unchart, complete the following steps:

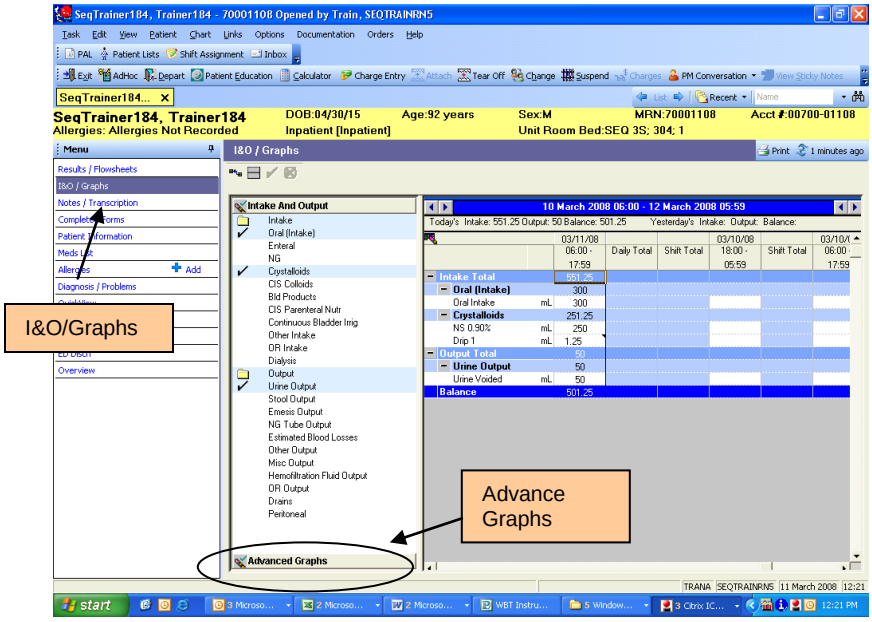
You can follow the steps previously outline in pages 17 to 18
OR you can complete the following steps:

1. Go to **Completed forms** in the Table of Contents
2. Select the Intake and Output form you want to unchart or modify
3. **Right click** that form
4. Select **unchart** or modify.
5. If you want to **modify**: it will take you back to the Intake and Output form. Enter the correct values. **Sign** the form.
6. If you want to **unchart**: Enter comments to why you want to unchart. **Sign** the form.

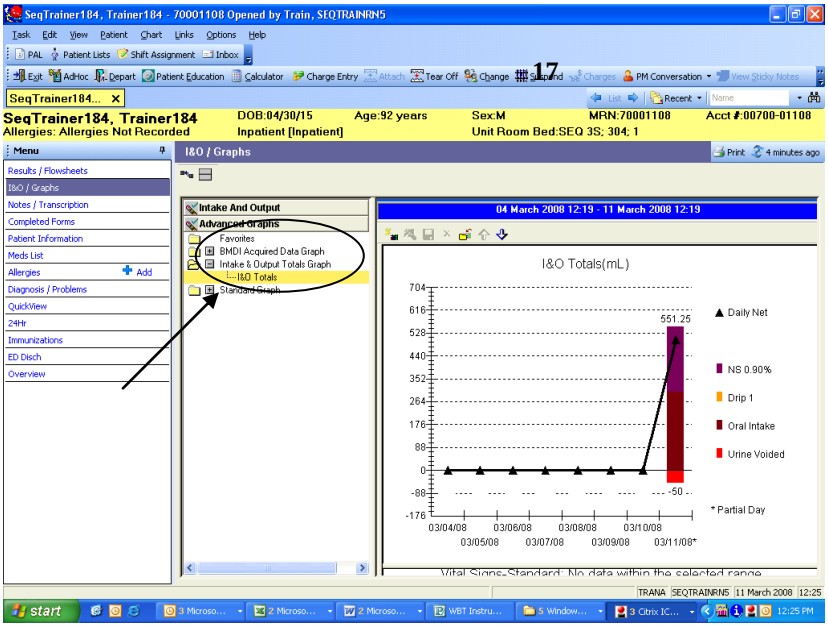
VIEWING I&O GRAPHS

To view the graphical content or to view historical I&O with details, complete the following steps:

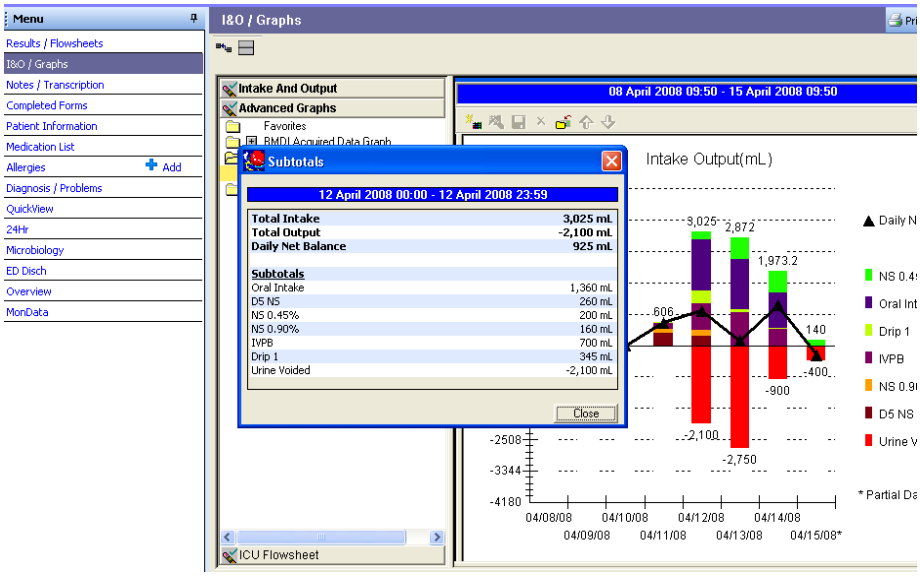
1. Go to **I&O/Graphs** from the Table of Contents
2. Click "**Advanced Graphs**".



3. Click the **Plus (+)** sign next to Intake and Output Totals Graph
4. Select **I&O Totals**
5. Graph will display



6. To view details, click the **triangle** (daily net) or the **graph bar** for that particular day. The subtotal box will pop up showing your Total Intake, Total Output, Daily Net Balance and the Subtotals for that day.

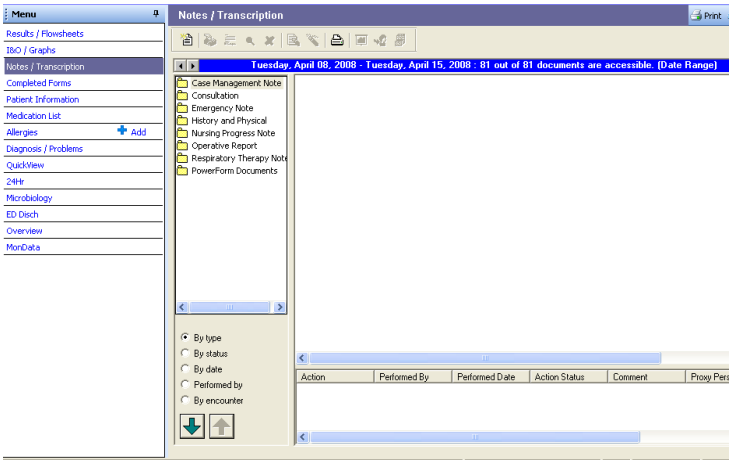

Menu
Results / Flowsheets
I&O / Graphs
Notes / Transcription
Completed Forms
Patient Information
Medication List
Allergies
Add
Diagnosis / Problems
QuickView
24Hr
Microbiology
ED Disch
Overview
MonData
I&O / Graphs
Intake And Output
Advanced Graphs
Favorites
08 April 2008 09:50 - 15 April 2008 09:50
Subtotals
12 April 2008 00:00 - 12 April 2008 23:59
Total Intake 3,025 mL
Total Output -2,100 mL
Daily Net Balance 925 mL
Subtotals
Oral Intake 1,360 mL
D5 NS 260 mL
NS 0.45% 200 mL
NS 0.90% 160 mL
IVPB 700 mL
Drip 1 345 mL
Urine Voided -2,100 mL
Close
Intake Output(mL)
3,025
2,872
1,973.2
606
140
-400
-900
-2,100
-2,750
-2508
-3344
-4180
04/08/08
04/09/08
04/10/08
04/11/08
04/12/08
04/13/08
04/14/08
04/15/08*
Daily N
Oral Int
Drip 1
IVPB
D5 NS
Urine V
* Partial Da
ICU Flowsheet

NOTES/TRANSCRIPTION

This is where you can add your nursing progress notes, view and read H&P. OP reports, RT, PT, case management notes, and other transcribed notes.

To access notes/transcription, complete the following steps:

1. Click Notes/Transcription from the Table of Contents.
2. Double click the specific folder.
3. Double click the specific note to open the document.



Notes can be sorted based on:

- Document type
- Date
- Status of Completion
- Author or Encounter

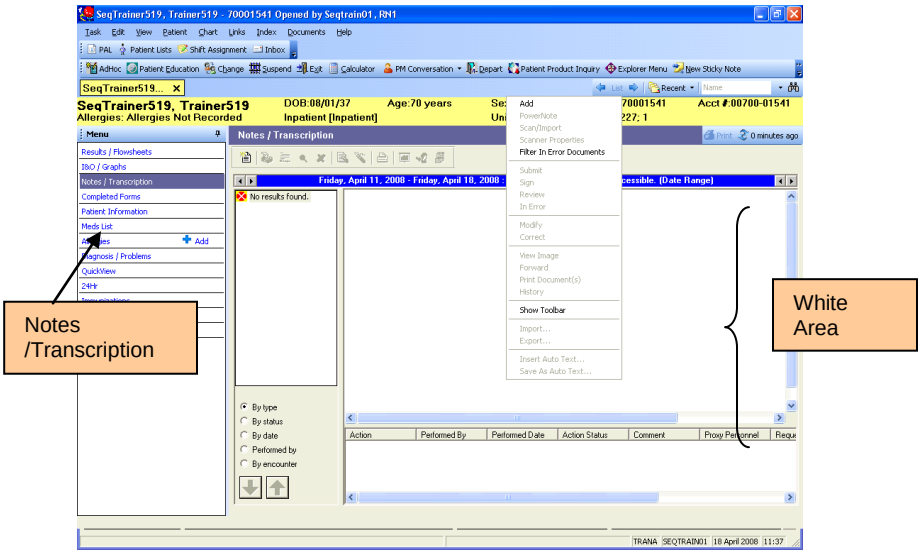
DID YOU KNOW

The default screen for Note/Transcription is "Document Type"

Add a Note

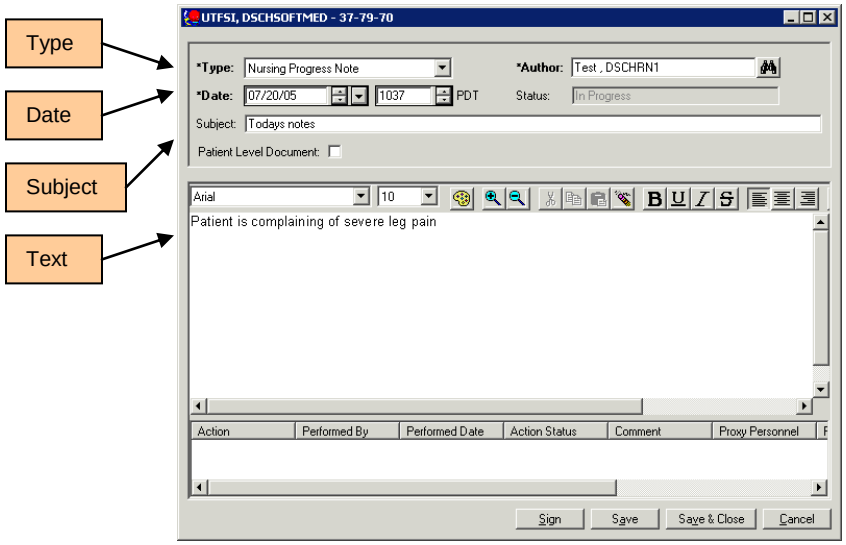
To add a note to a patient's chart complete the following steps:

1. Click **Notes/Transcription** from the Table of Contents
2. **Right**-click the white area in the "Document window" to display the "Add Document" option.



3. The “Note” window displays. Complete the following fields:

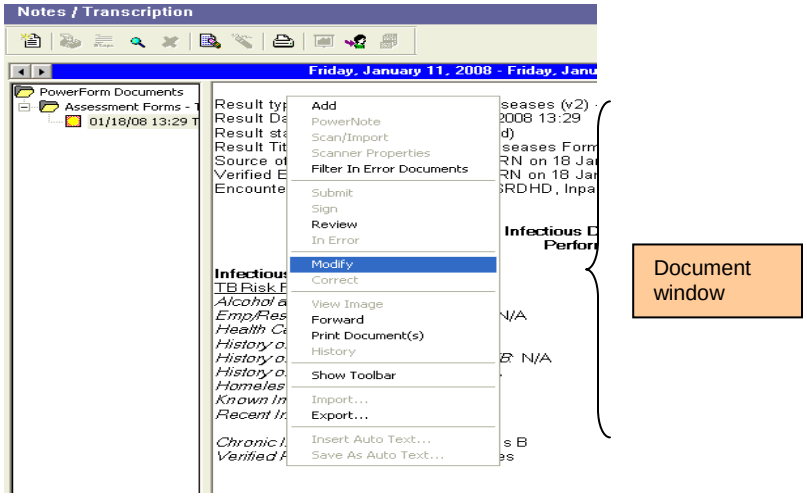
   - **Type:** Use the drop down arrow to select note type from the list.
   - **Authors**: The user’s name is defaulted
   - **Date and time:** Defaulted to the current date and time. You can make a change by using the arrows located to the right of the “Date and Time” fields
   - **Subject:** Type a subject
   - **Text window:** Type note. When done click the **Sign** button located at the bottom of the screen.



Modify a Note

To modify a typed note you need to complete the following steps:

1. **Double**-click to folder and note you wish to modify
2. **Right**-click on the “Document Window” and select “Modify”



3. The original note displays the cursor below “Insert Addendum Here” statement.
4. Type in your modification and click either the **Update** or the **Sign**

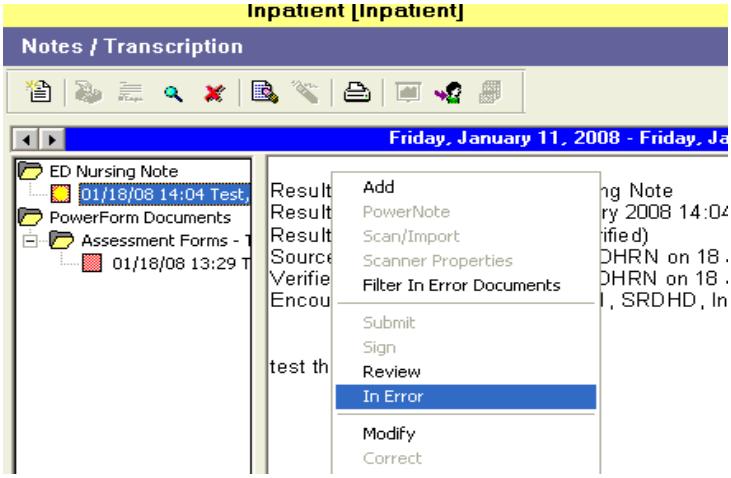
button at the bottom of the screen.

5. The modified notes displays the modification as well as a red banner stating “Document Contains Addendum”
6. The document trail is also updated to reflect the following:
7. The type of action (Modify)
8. Performed by: name of the user
9. Date and time and Status

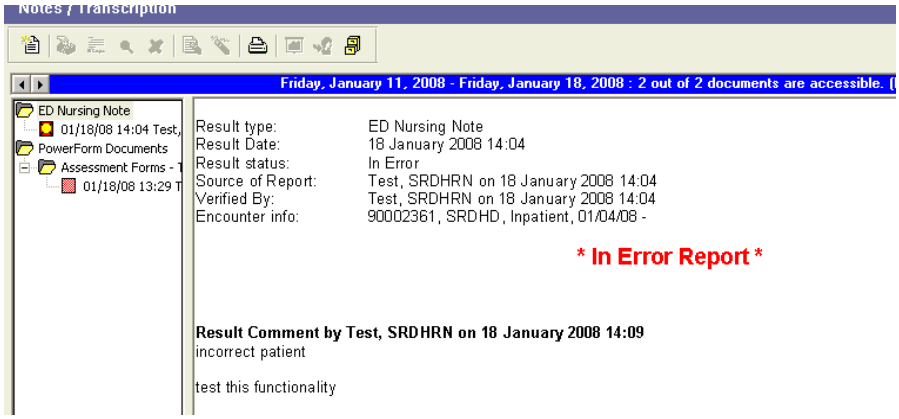
Unchart an Error Note

To Unchart an Error note you need to complete the following steps:

1. **Double**-click the folder and the note you wish to unchart.



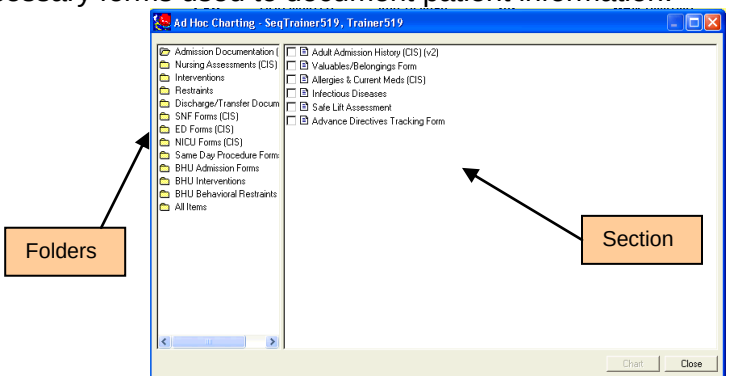
2. Right click and select “In Error”. The “Result Uncharting” window displays. Type in your reason for “uncharting”.
3. Click **OK**.
4. Red “In Error Report” banner displays. The Navigator window denotes the note with a red and yellow box.


Notes / Transcription
Friday, January 11, 2008 - Friday, January 18, 2008 : 2 out of 2 documents are accessible.
ED Nursing Note
01/18/08 14:04 Test,
PowerForm Documents
Assessment Forms - T
01/18/08 13:29 T
Result type: ED Nursing Note
Result Date: 18 January 2008 14:04
Result status: In Error
Source of Report: Test, SRDHRN on 18 January 2008 14:04
Verified By: Test, SRDHRN on 18 January 2008 14:04
Encounter info: 90002361, SRDHD, Inpatient, 01/04/08 -
* In Error Report *
Result Comment by Test, SRDHRN on 18 January 2008 14:09
incorrect patient
test this functionality

AD HOC CHARTING

Ad Hoc Charting Structure

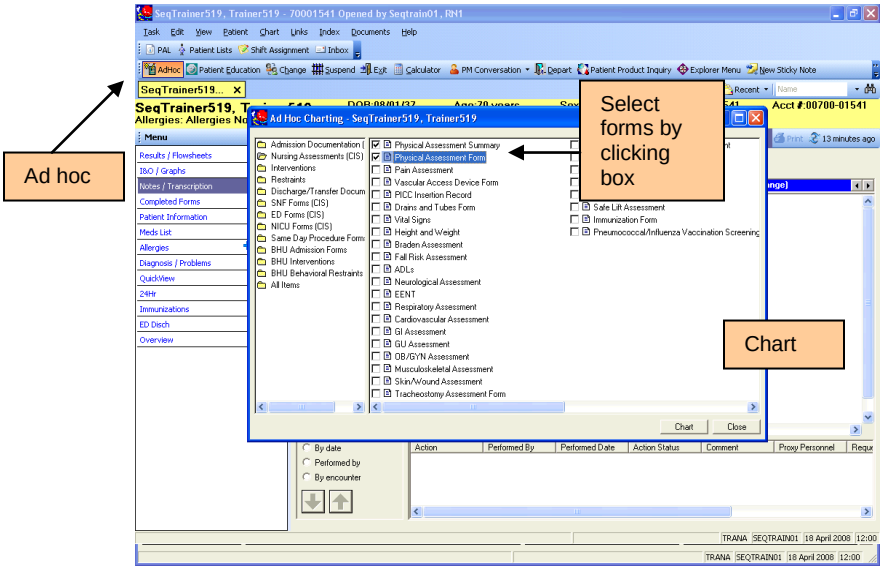
Ad Hoc forms can be accessed through the **toolbar**. Ad Hoc charting consists of folders on the Left hand column and forms on the right hand column Within each form, are sections. The folders contain all the necessary forms used to document patient information.



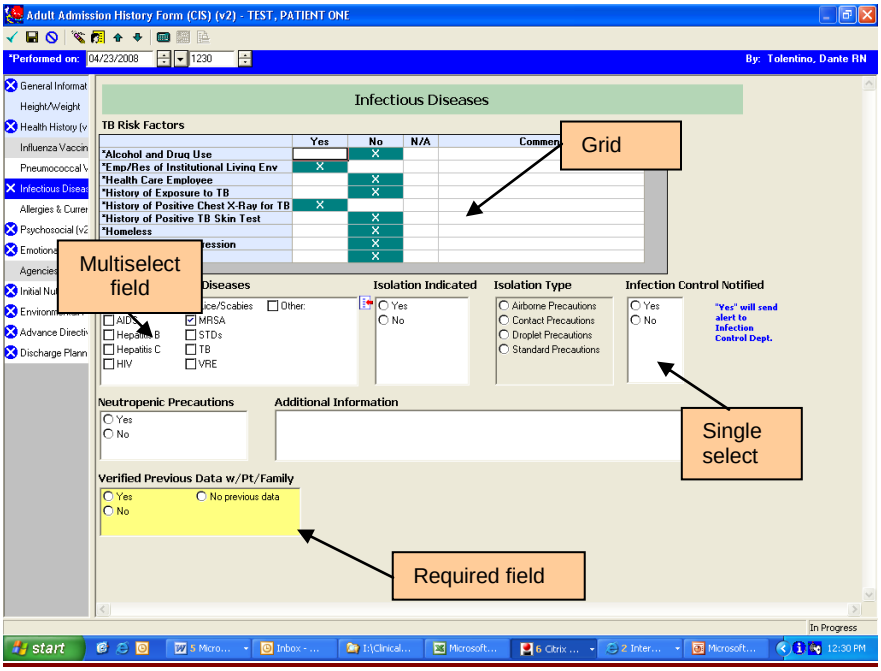
Open Ad Hoc Folder and Select a Form

Clinician roles determine the type of ad hoc forms they are able to access. There are several types of Ad Hoc folders across disciplines. To open an Ad Hoc folder and select a form complete the following steps:

1. Make sure you are in a patient's chart.
2. Single click the **Ad Hoc Charting** icon from the toolbar.
3. The Ad Hoc Charting window opens to the default folder based on your role and login ID
4. To select one of the forms, click on the square box to the left of the subfolder. A checkmark displays.
5. Click the **Chart** button on the bottom right side of the window.

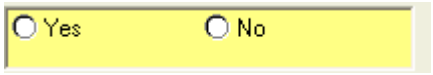


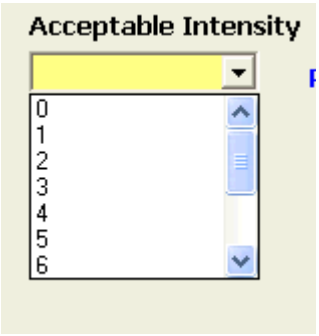
Alpha/Numeric fields in ad hoc



Single Alpha-Numeric fields:

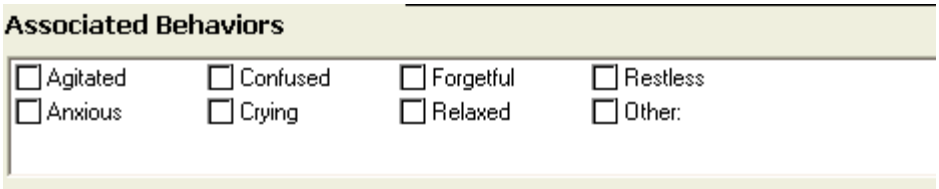
When you see a radio button or a drop down menu, you can only select one response.





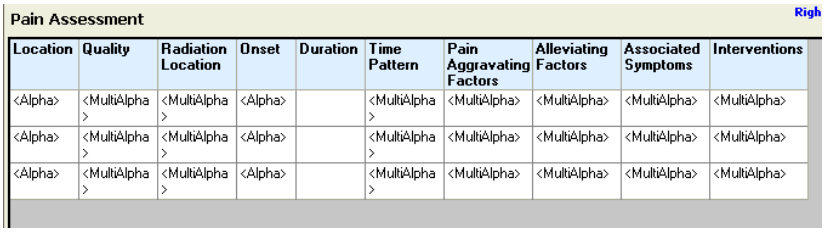
Multi Alpha-Numeric fields:

When you see a check box, you can select multiple responses.



Power Grid

To chart, click the cell where it says <Alpha> or <MultiAlpha>



Add a Row to a Grid for a New Entry

1. **Right**-click on the cell where you need to add the row.
2. A submenu displays.
3. Select “Add Row” and a row is added to the bottom of the grid.

Delete a Row from a Grid

1. **Right**-click on the cell where you need to delete the row.
2. A submenu displays.
3. Select “Delete Row” and the row is deleted.

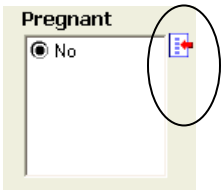
Clear the Contents of a Cell

1. **Right**-click on the cell where you need to clear the charted data.
2. A submenu displays.
3. Select “Clear” and the cell data is deleted.

Numeric or Text Fields:

Last Charted Value Fields:

This field has been designed to retain infrequently changed patient data to reduce duplicate work.



Reference Fields:

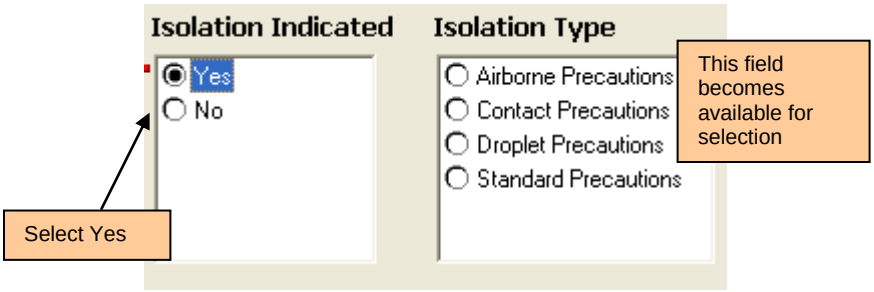
Review reference information needed to make the correct documentation selection.

To view an example (Nursing) of a reference text field

1. Click on the **Ad Hoc Charting** icon
2. Select “Physical Assessment Summary”
3. Click the radio button next to the “WNL-Ref Info” field to the right of the “Neuro/Behavioral/Glasgow Assess/Reassess” section.
4. The “Neurologic Reference” window displays Neurological Reference information.
5. To exit this window, click the **Curved** icon at the top left or **X** in the right hand corner.

Conditional Fields:

In Ad Hoc forms, specific responses will trigger related documentation fields such as “Isolation Indicated” and “Isolation Type”. If your answer was YES to “isolation indicated”, the “isolation type” field is available for you to make a selection.



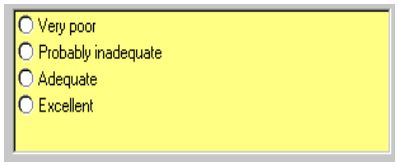
Alerts Fields:

Alert Key Fields are designed to automatically send an alert message to the appropriate Care provider. Example:

- Pastoral Care
- Dietitian
- Case Manager
- Infection Control Nurse.
- Suicide Watch Report

Required Fields:

Some Ad Hoc forms contain required fields. Some forms can’t be signed until all required fields are completed. Required fields are highlighted in yellow. The example shown below is a nursing’s form required field



COMPLETED FORMS

Completed Forms is where you can view ad hocs forms completed for the patient during their stay in the hospitals. Forms include but not limited to Adult Admission History form, Vital Signs, Physical Assessment, Multidisciplinary Education, etc.

To access Completed forms, click “Completed forms” in the Table of Contents

To view the contents of a folder:

- Click the + sign located to the left of the folder

To hide the contents of a folder:

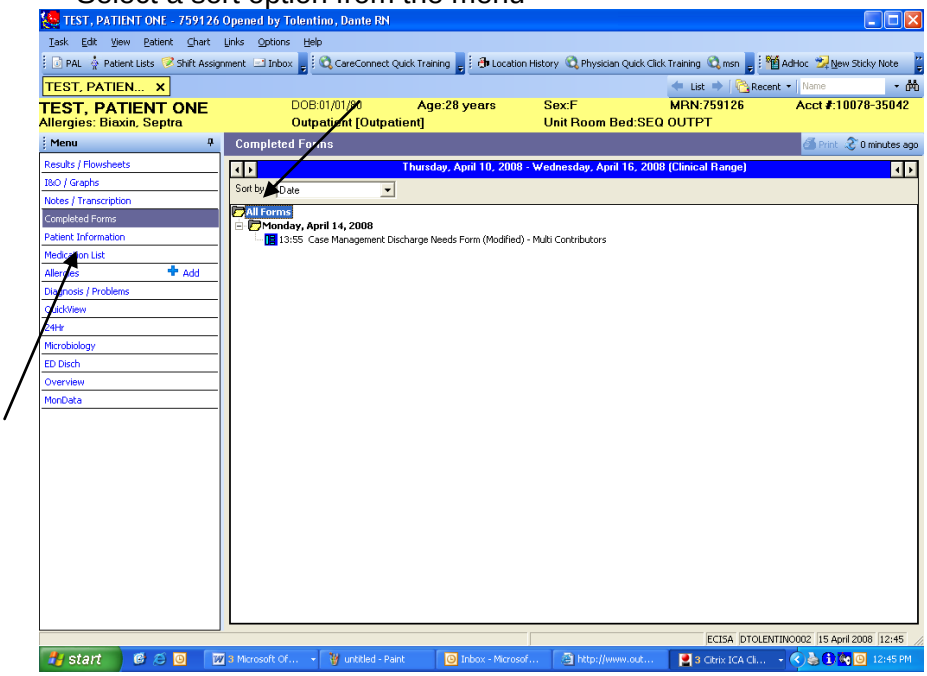
- Click the (-) minus sign located to the left of the folder

To view a folder document:

- Click the + sign to the left of the desired folder
- Located the desired document in the folder and **double**-click it, when done click the **X** box located at the right upper corner to exit

To sort folders, complete the following steps:

- Click the “Sort by” field down arrow
- Select a sort option from the menu


TEST, PATIENT ONE - 759126 Opened by Tolentino, Dante RN
TEST, PATIENT ONE
Allergies: Biaxin, Septra
Age:28 years
Sex:F
MRN:759126
Menu
Completed Forms
Thursday, April 10, 2008 - Wednesday, April 16, 2008 (Clinical Range)
Sort by: Date
All Forms
Monday, April 14, 2008
13:55 Case Management Discharge Needs Form (Modified) - Multi Contributors

Modify a Form

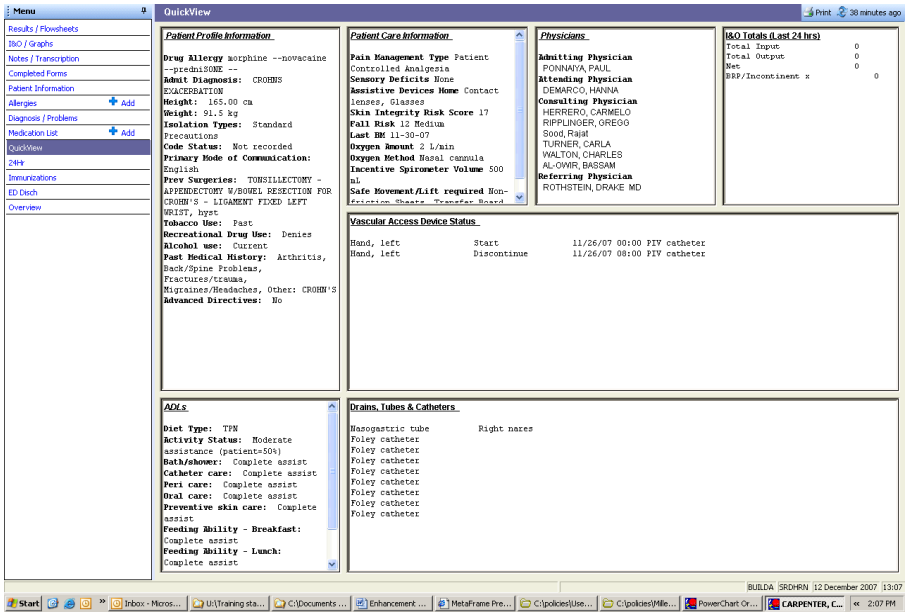
1. Click on the Patient’s “Completed Forms ” Section
2. **Right**-click on a form. Example “Adult Admission History Form”. Select “Modify” from the submenu option
3. Enter a modification on the form
4. Sign your form using the **Sign** icon located on the far upper left corner.
5. Click the **Refresh** button to refresh the screen

QUICKVIEW

The Quick View is equivalent to the 24 hr Kardex displays the following:

- Patient Profile Information
- Patient Care Information
- Physicians
- I&O Totals Last 24hrs
- Vascular Access Device Status
- ADL's
- Drain, tubes & Catheters.

To access, click "**QuickView**" from the Table of Content"

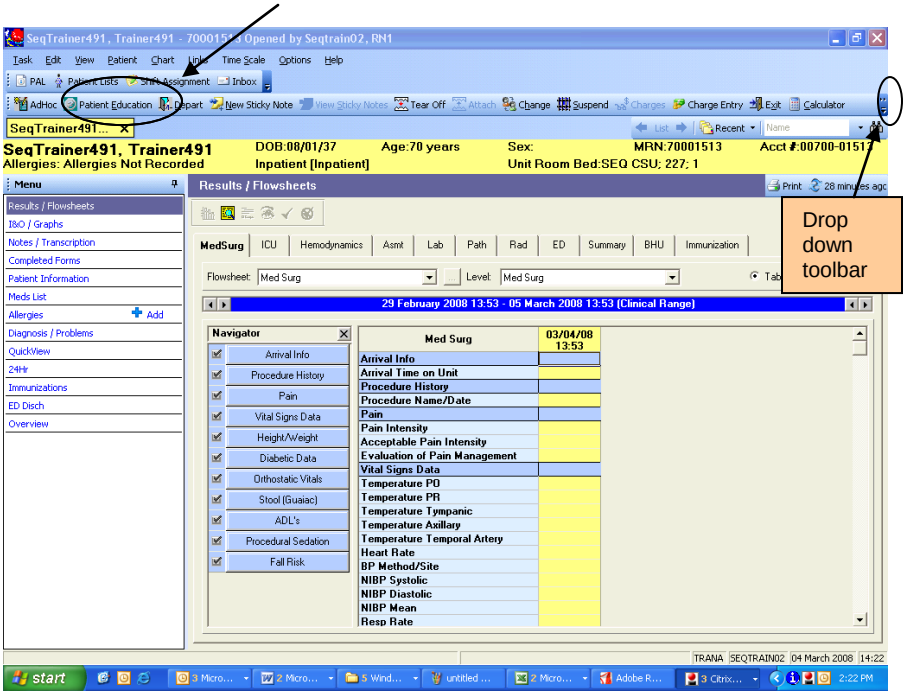


Note: QuickView pulls data from multiple locations and can take several seconds to load and open.

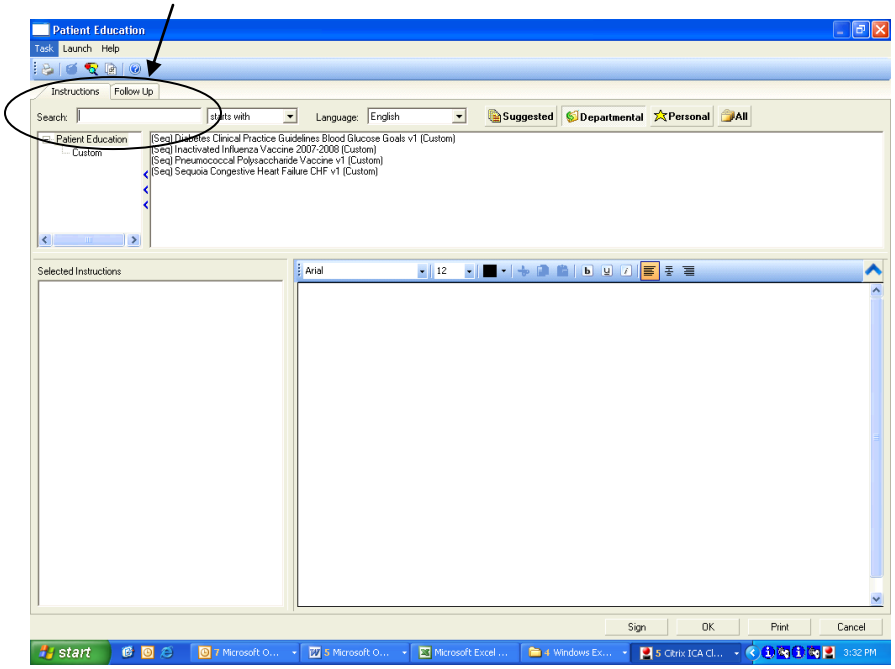
PATIENT EDUCATION HANDOUTS

Patient Education icon is used to search, select and print patient education handouts to your patients. To access patient education, complete the following steps:

1. Single click the **"Patient Education"** icon located in the toolbar.



2. The **patient education handout screen** will pop up
3. **Search** the desired education handout you want to give in the "**Search**" field located on the upper right side corner.



CAN'T FIND IT?

Can't find your patient education icon? It might be hiding! Click the drop down arrow at the end of the toolbar to show more icons.

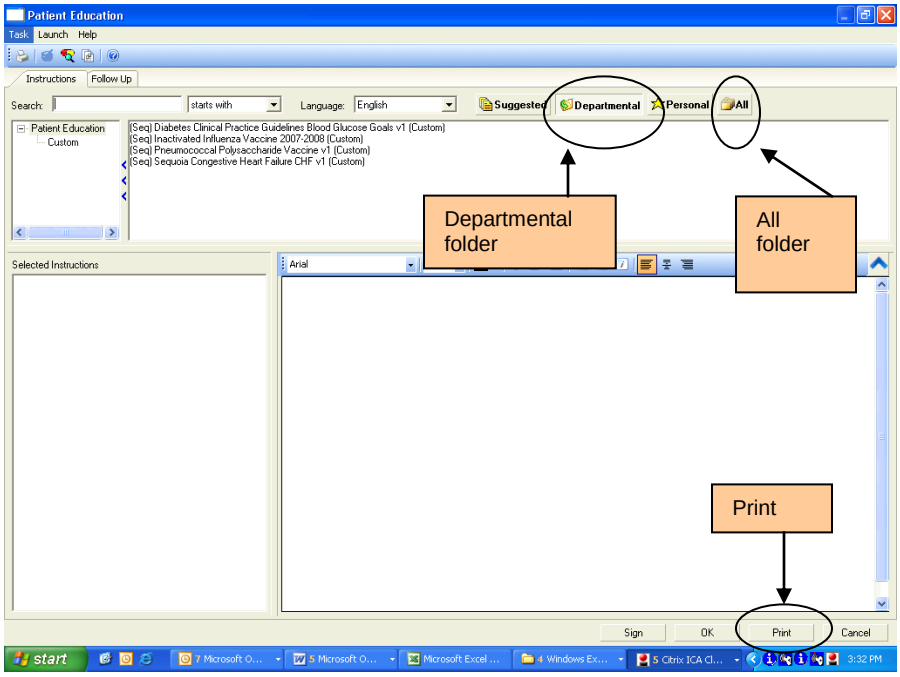
Remember you can rearrange your icons! To do this, turn to page 29.

DID YOU KNOW

Any Sequoia- specific handouts will be in the Departmental Folder. All of these handouts will start with "(**Seq**)".

To find more tips using the patient education handout, turn to page 22.

4. Make sure you click the "**Departmental folder**" first located in the upper left side of the screen.
5. If unable to find the handout under "departmental", click the "**All**" folder.



6. Scroll to find the desired education handout.
7. If you find it, **double click** the specific handout to view the content of the handout.
8. Click "**Print**". You can click **OK** if you do not want to print the handout.

DID YOU KNOW

Patient Education handouts completed in the "Patient Education" form will display on the left side of the screen and it will list it in the Clinical Summary under Education Handouts.

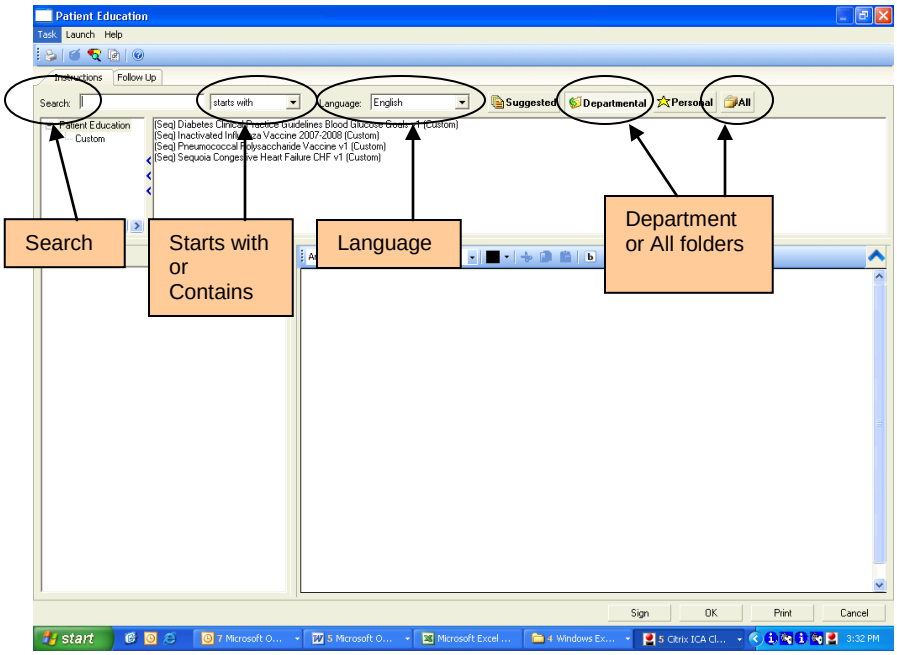
DID YOU KNOW

Whenever you select a

patient education handout, the content of that handout displays on the Clinical Summary. If the patient does not wish to receive another copy of the handout, single click the "Printer icon" next to that particular handout in the depart screen. This will remove the text rendition of the handout from the Clinical Summary.

TIPS FOR SELECTING AND PRINTING PATIENT EDUCATION DOCUMENTS

- When searching for a Sequoia-specific handout, make sure to go to "**Departmental folder"** to see if we have Sequoia approved handouts available to use in the system.
- When searching, **type in only the first three letters of a topic** of your choice. For example, if you are interested in searching congestive heart failure, type "**Con**" in the search box.
- You can search by "**Starts** with" or "**Contains**".
- Sequoia-specific handouts will have the title of the handout start with (Seq).
- If your department uses a particular handout, the title will start with **(Seq + department name).** For example, for MSO, it will be under (**Seq MSO)**
- If you don't see what you intend to give to your patient, search the handout under **ALL** folder.
- To search for Spanish documents, change the "**Language**" drop in box to "**Spanish**"
- Make sure to select all the handouts that you want to give to your patient before you click **PRINT.**
- Once you print, that patient education handout will be associated to that patient's record.



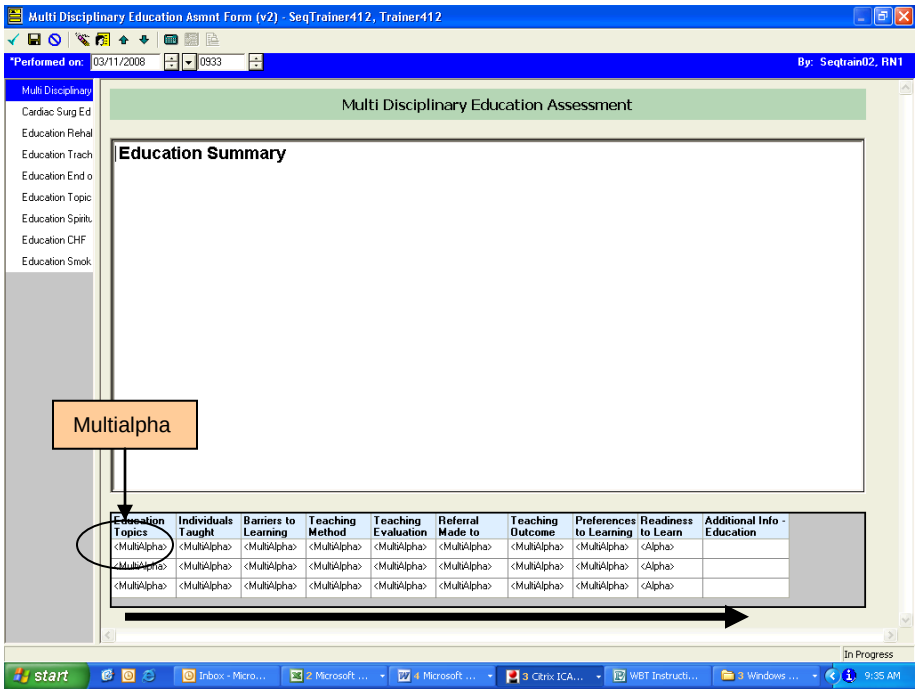
MULTI-DISCIPLINARY EDUCATION ASSESSMENT FORM (STAND ALONE – AD HOC FORM)

The multidisciplinary Education Assessment Form is used to document education provided to the patient conducted by different disciplines.

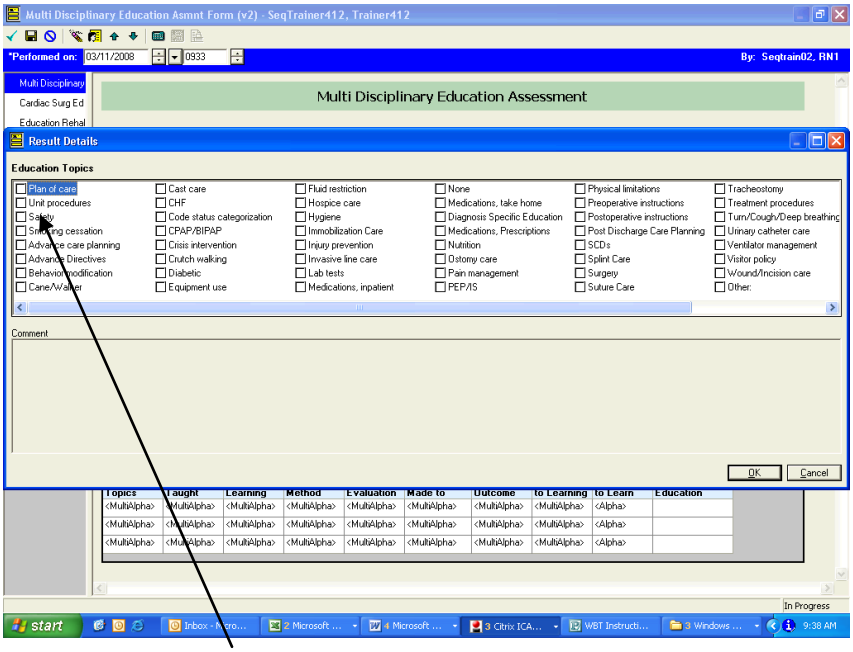
It can be accessed two different ways. This section will show you how to access the “stand alone form”. It is accessible in ad hoc>Nursing folder or on Depart> Interdisciplinary Education.

To complete the stand-alone Multidisciplinary Education Assessment form, complete the following steps:

1. Click the “ad hoc” icon from the toolbar.
2. Depending on your position, the multidisciplinary ad hoc form will be located in different folders. For nursing, it will be under Nursing Assessment folder. For other disciplines, it will be under Multidisciplinary Education folder.
3. Select the check box next to the form
4. Click chart
5. Charting is done at the bottom of the screen, where you see a grid-like table. Charting is done from left to right.
6. To start charting, click the cell where you see the word “<Multialpha>”

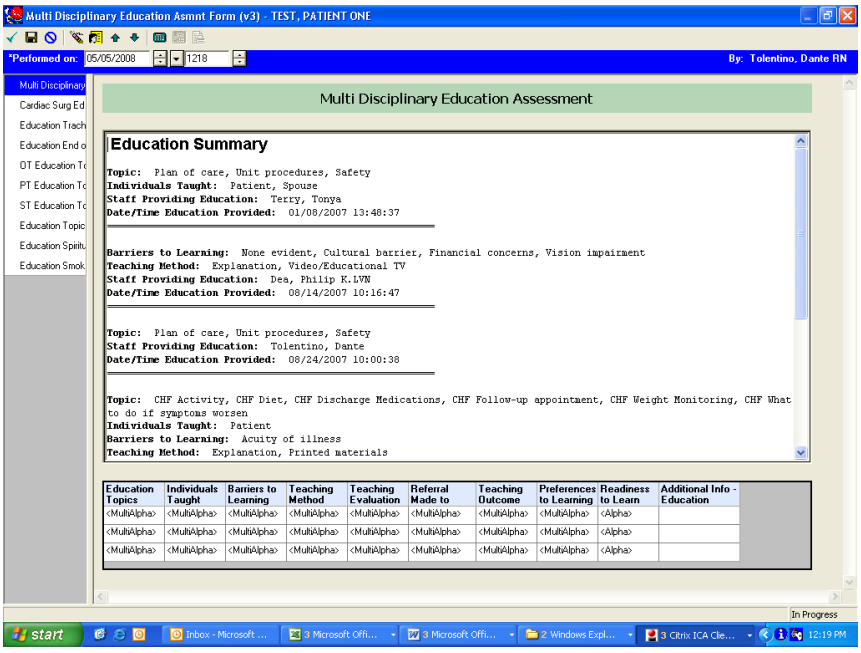


7. The Result Details will pop up.



8. Select the check box next to the topic you want to document.
9. Click OK.
10. Follow steps #6 - #10 for the rest of the cells.
11. When you are done, click Sign, which is located at the upper right of the screen,

The topics/details that you charted will be summarized in the "Education Summary".


Multi Disciplinary Education Asmnt Form (v3) - TEST, PATIENT ONE
Multi Disciplinary Education Assessment
Education Summary
Topic: Plan of care, Unit procedures, Safety
Individuals Taught: Patient, Spouse
Staff Providing Education: Terry, Tonya
Date/Time Education Provided: 01/08/2007 13:48:37
Barriers to Learning: None evident, Cultural barrier, Financial concerns, Vision impairment
Teaching Method: Explanation, Video/Educational TV
Staff Providing Education: Dea, Philip K.LVN
Date/Time Education Provided: 08/14/2007 10:16:47
Topic: Plan of care, Unit procedures, Safety
Staff Providing Education: Tolentino, Dante
Date/Time Education Provided: 08/24/2007 10:00:38
Topic: CHF Activity, CHF Diet, CHF Discharge Medications, CHF Follow-up appointment, CHF Weight Monitoring, CHF What to do if symptoms worsen
Individuals Taught: Patient
Barriers to Learning: Acuity of illness
Teaching Method: Explanation, Printed materials

To access the Multidisciplinary Education Assessment form through Depart, turn to page 43.

DEPART PROCESS

Depart is synonymous to “Discharge”. When you are ready to discharge or transfer you patient, click the “Depart” icon on the toolbar to start.

Required elements of the Depart Process:

1. **Patient Education Handouts** – inventory of handouts and list of handouts given to the patient during their stay.

2. **Medication Education Handouts** – inventory of medication handouts. Sequoia IS NOT using this at this time.

3. **Interdisciplinary Education** – same as the Multidisciplinary Education Assessment Form. It is used to document individualized topics, barriers, readiness for learning, and others.

4. **Cardiac Surgery Education** – used to document education given to cardiac surgery patients (if applicable).

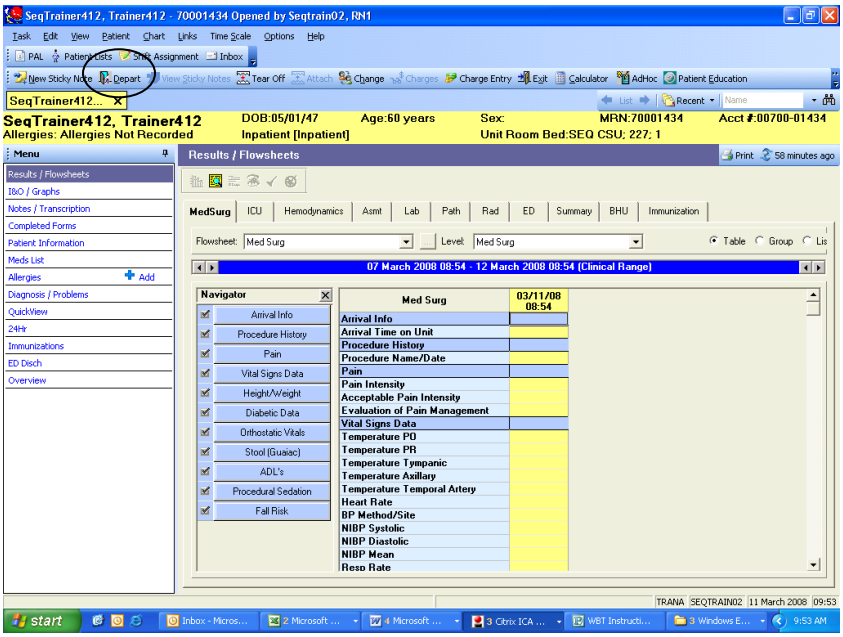
5. **Interdisciplinary Readiness for Discharge** – used by Case Management. Also an alternate way to access Education form and Discharge Note.

6. **Valuables and Belongings** – to update Valuables and Belongings list

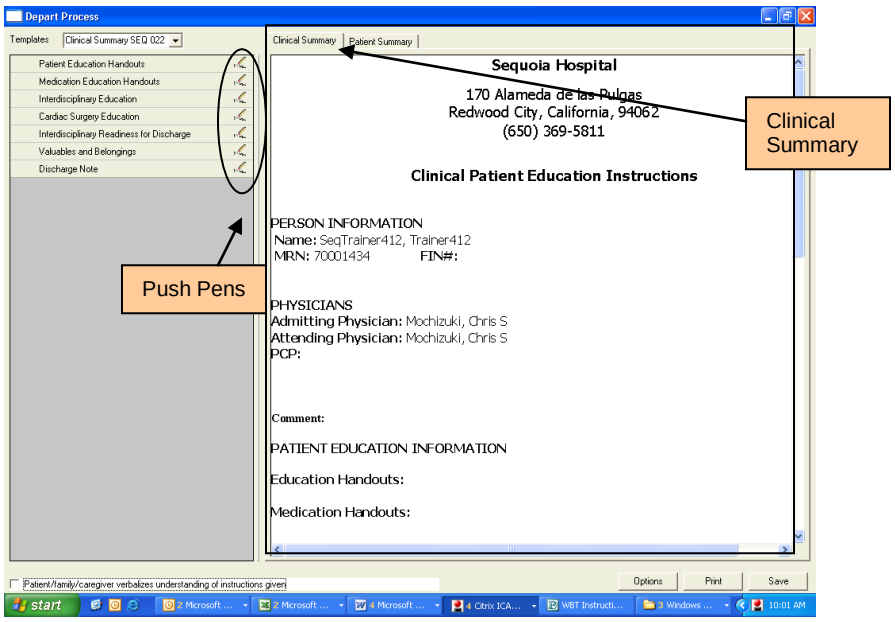
7. **Discharge Note** – used to complete patient discharge/transfer information.

To access depart, complete the following steps:

1. Click “**Depart**” on the toolbar.



2. Depart process defaults to “Clinical Summary tab”.



From here, you can complete all the Required elements mentioned above.

Patient Education Handouts

If you want to provide **additional education** upon discharge complete the same steps used to select the handout provided in “Patient Education” instructions.

1. Click **Push Pen** next to the word “Patient Education Handouts”
2. **Search** for the handout by typing the first three letters of the handout
3. Make sure that the Folder is “**All**” or if you are searching **Sequoia-specific**, make sure the folder is “**Departmental**”.
4. Click **OK**
5. Patient education displays on “**Clinical Summary**” & “**Patient Summary**”

Medication Education Handouts

Sequoia Hospital is currently not using this functionality.

Interdisciplinary Education

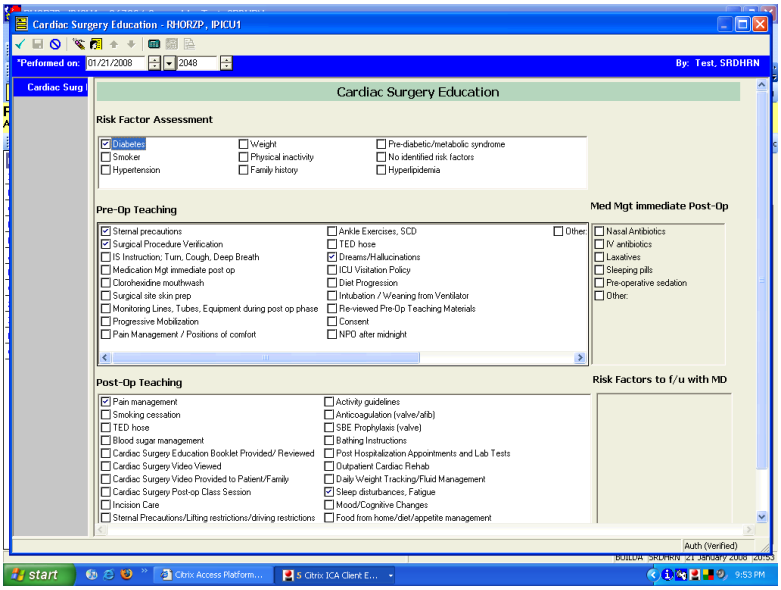
This is the same form as the stand-alone Multidisciplinary Education Assessment form. To complete, do the following:

1. Click **Push Pen** next to the word “Interdisciplinary Education”
2. Click the **cells** make selection from the form
3. Click **OK** to close form
4. **Sign** form
5. Selected information displays in the top section of the screen, Clinical Summary and Patient Summary

For further instructions, turn to page 23 and follow steps #6 - #10.

Cardiac Surgery Education

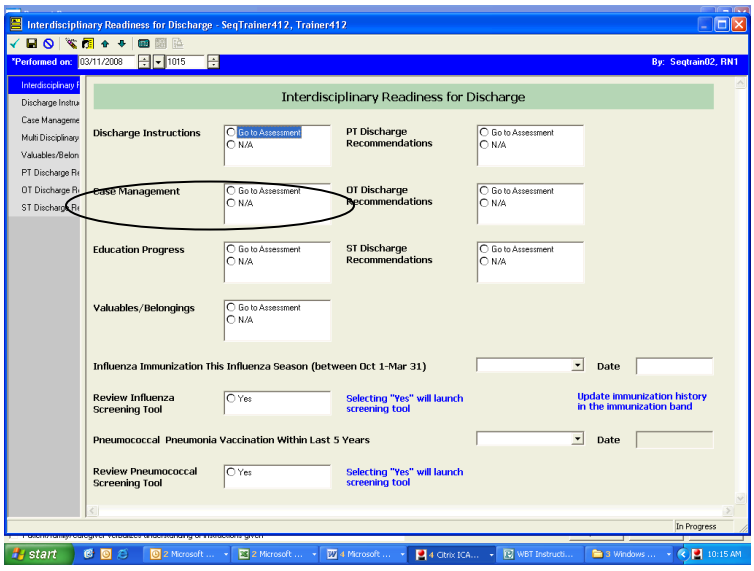
1. Click **Push Pen**
2. Select **applicable information** found on the cardiac surgery education form
3. When done, **Sign** form
4. Information displays on the “Clinical summary” & Patient Summary”



Interdisciplinary Readiness for Discharge

This will be completed by **Case Management** only.

1. Click **Push Pen** next to the word “Interdisciplinary Readiness for Discharge”
2. Complete form by clicking on “**Go to Assessment**” radio button under Case Management



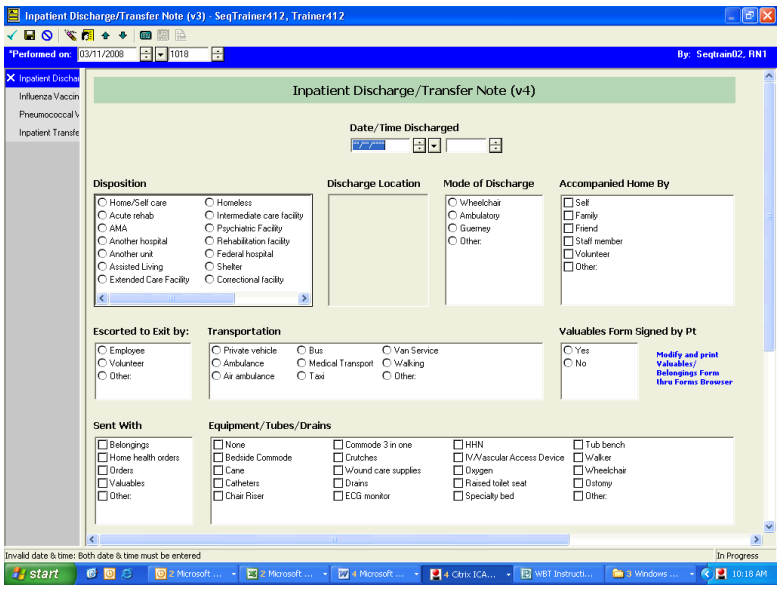
3. Checkmark applicable information
4. Click **hook icon** on the left upper corner to **return** to original form

Valuables and Belongings

1. Click **Push Pen** next to the word “Valuables and Belongings”
2. Complete form by selecting applicable information
3. Click **Sign**
4. Information displays on the Patient Summary tab

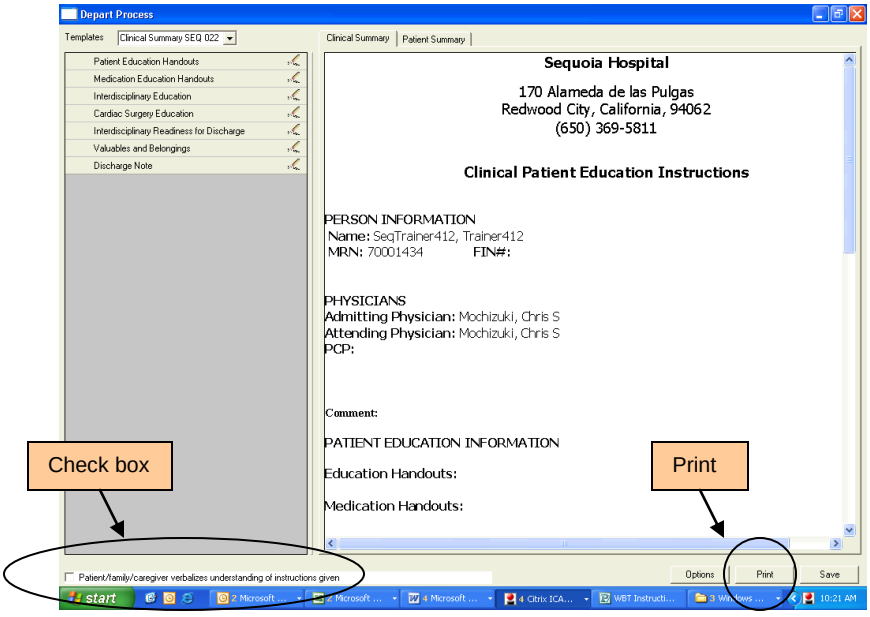
Discharge Note

1. Click **Push Pen**
2. Complete form including required fields
3. When done click **Sign**



After you have completed all the required elements, make sure to select the **check box at the bottom of the depart** screen stating that the patient/family/caregiver verbalizes understanding of instructions given.

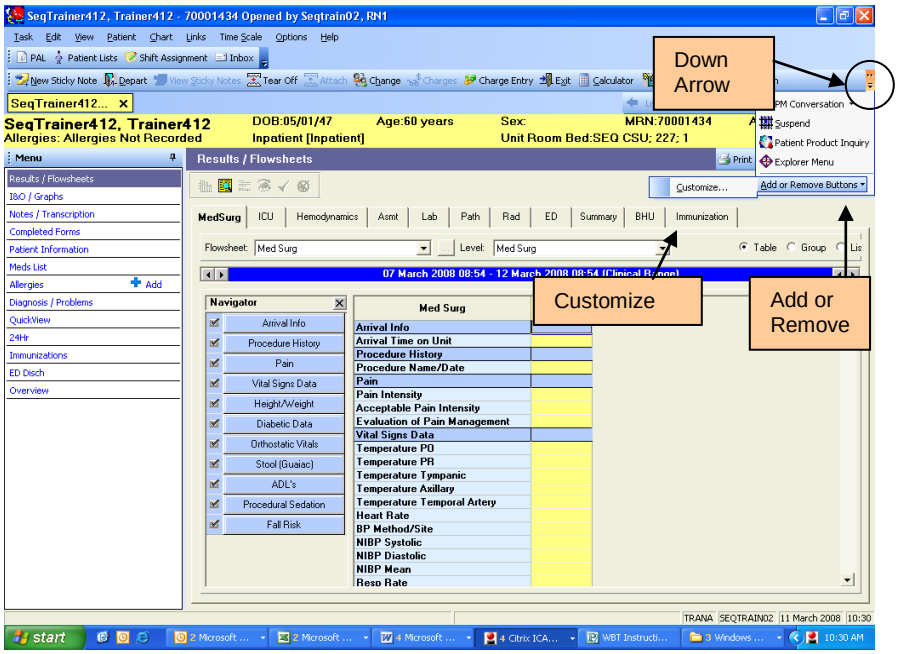
When patient is ready to be discharged/transferred, **PRINT** the Clinical Summary and hand it to your patient.



ADVANCE USER PREFERENCES

Rearranging your icons in the toolbar

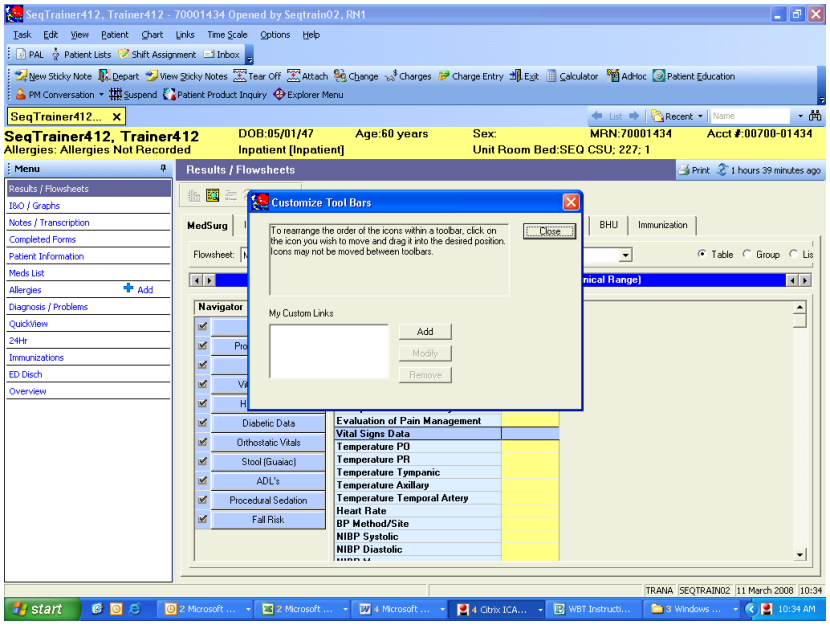
1. Single click the **down arrow** at the end of the toolbar.
2. Select "**Add or Remove buttons**"
3. Select "**Customize…**"



DID YOU KNOW

You can only drag icons in the 2nd row and 3rd row of the toolbar. Any icons in the 2nd row will show up and any icons in the 3rd row will be hidden.

4. The "Customize Tool Bars" screen opens.
5. Start dragging the icons in the toolbar. You can re-arrange them to your liking.
6. After you're done, click "Close" from the "customize tool bars" screen.



7. Your changes will be stored as your toolbar preferences.

Changing timescale default

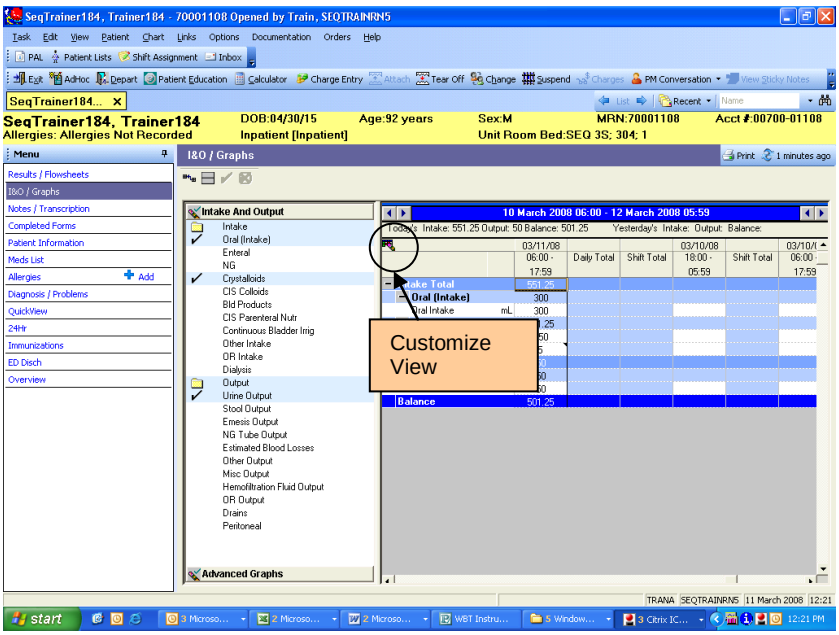
The current timescale default for your flowsheets, notes/transcriptions and completed forms is set to **Clinical Range** – which goes back the last 4 days and 1 day in advance.
You can change your default timescale to a different retrieval type. The following default are available in the system:

1. Clinical Range (Date Range)
2. Posting Range
3. Result Count
4. New Results
5. Admission date to current date

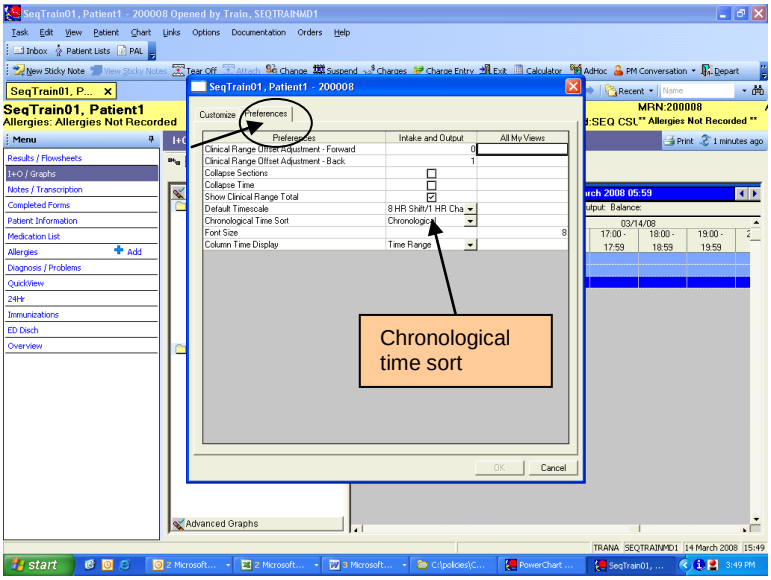
To change your default timescale, complete the following steps:

Changing I&O timescale

1. Go to **I&O/Graphs** from the Table of Contents
2. Click "**Customize View**" (below Today's Intake ... Output… Balance…detail)

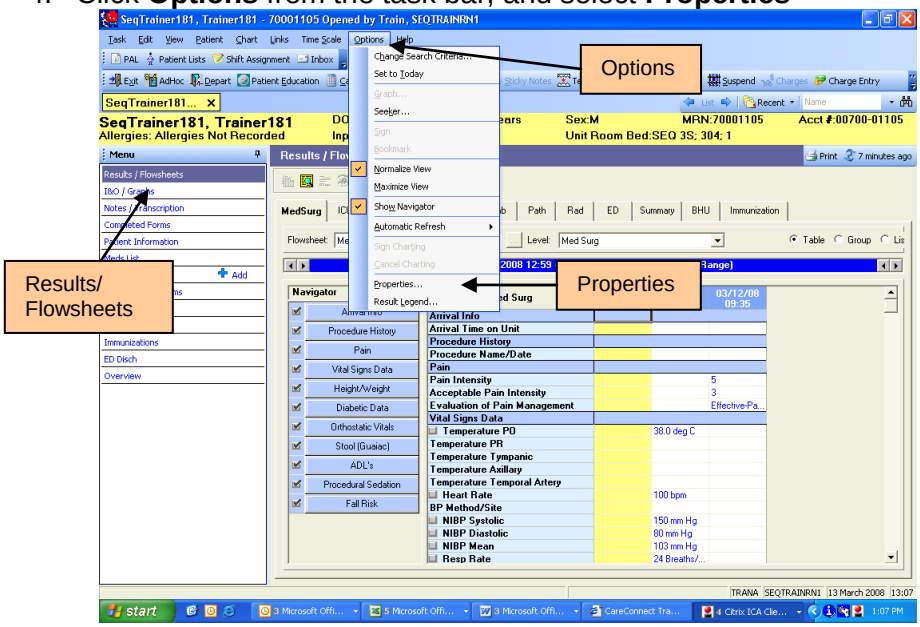


3. Click **Preferences** Tab
4. Under **Chronological Time sort**, click the drop down arrow and select either: chronological or reverse chronological.
5. Click **Ok**.

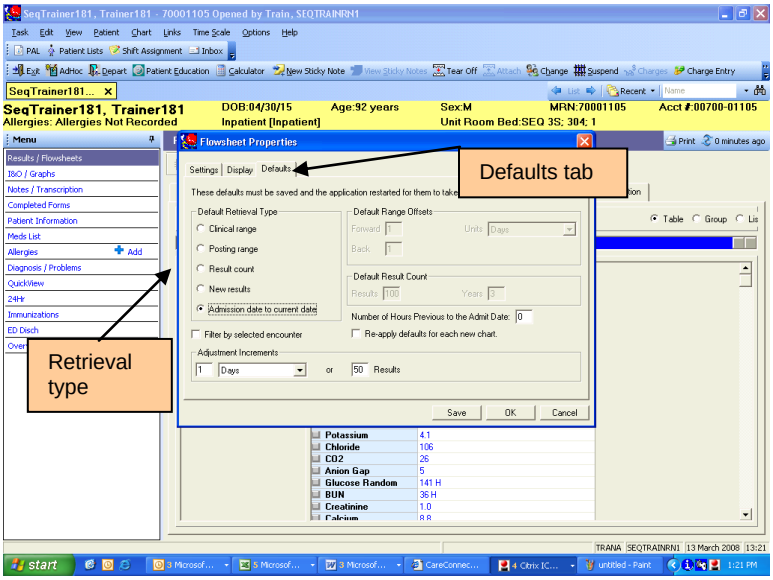


To change timescale default for Results/Flowsheets:

1. **Open** a patient's chart.
2. Click **Results/Flowsheets** from the **Table of Contents**.
3. Click **the specific flowsheet** you want to change the default (for example, **Lab** tab).
4. Click **Options** from the task bar, and select **Properties**



5. Click the **Defaults** Tab
6. Now select your **default retrieval type** preference.
7. Click **Save**.
8. Click **Yes** when it asks if you want to save current property settings.
9. Then click **OK**.

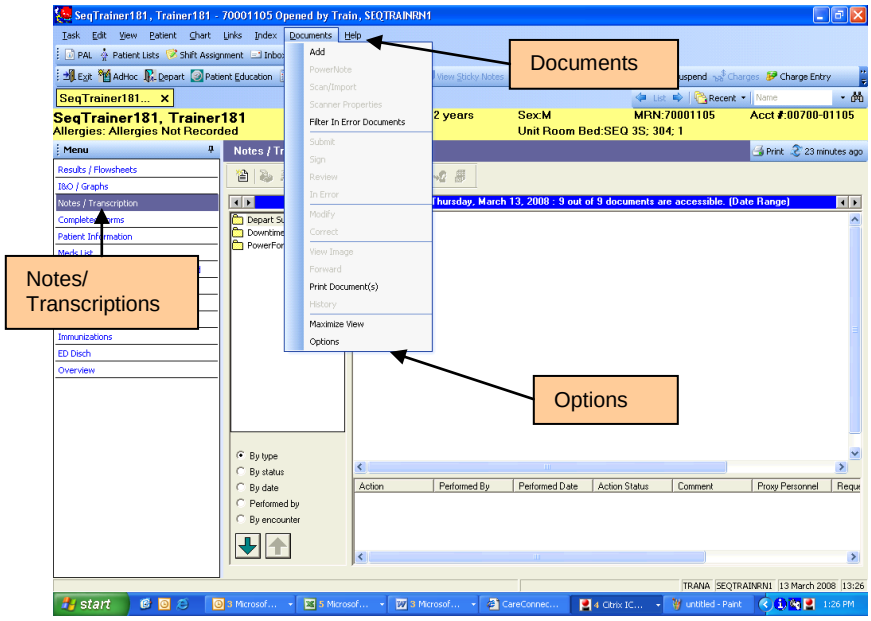


10. This only changes the flowsheet that you are in. **Follow steps #3 to 9** to change the default of every flowsheet.

Note: Selecting longer time periods for your default preference may result in addition time required to open flowsheets, notes/transcription.

To change the default timescale for Notes/Transcription

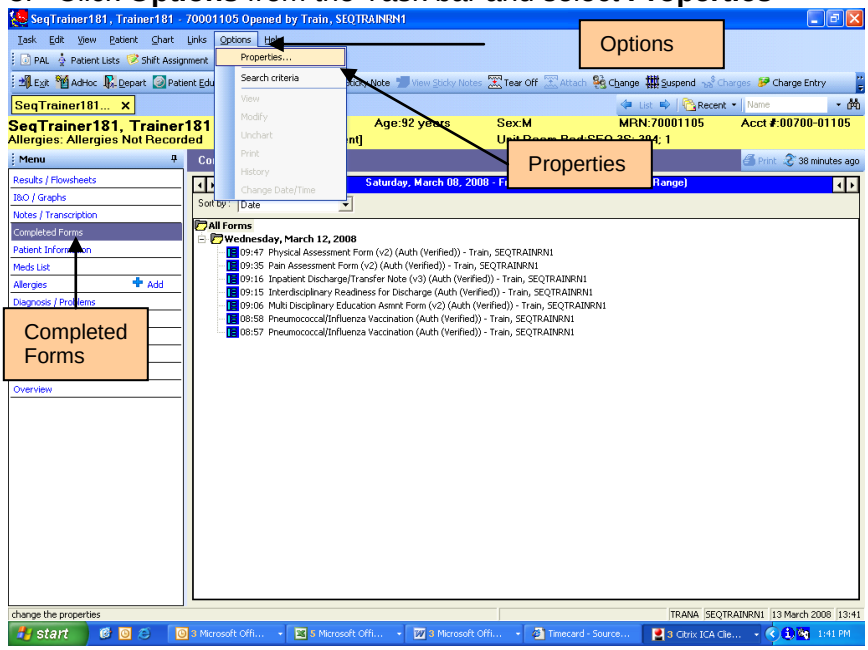
1. Make sure you are in a patient's chart.
2. Click **Notes/Transcription** from the Table of Contents
3. Click **Documents** from the task bar and select **Options**



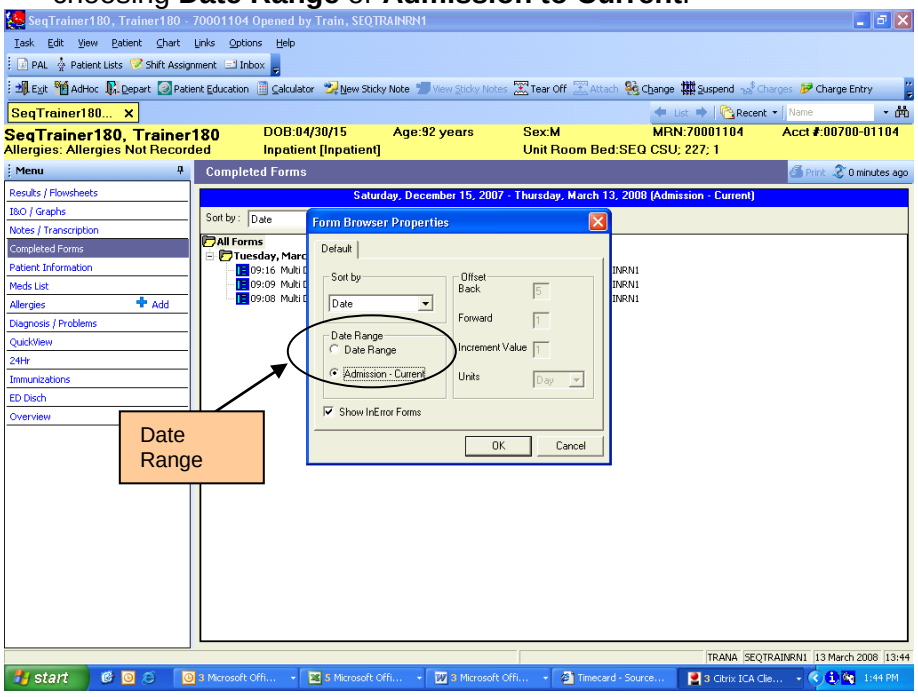
4. Click **Index Defaults** tab
5. Select your default in the "**Filter by**" option. You have a choice of d**ate range, document count or admission to current.**
6. Click **OK**.

To change timescale default for Completed Forms

1. Make sure you are in a patient's chart
2. Click **Completed Forms**
3. Click **Options** from the Task bar and select **Properties**



4. Select your default under **Date Range**. You have an option of choosing **Date Range** or **Admission to Current**.



5. Click **OK**

Note: You only have to change your default time scale preferences once. Once you change it, it will save that preference to your log in information, and when you open another patient's chart it will default to what you set it to.

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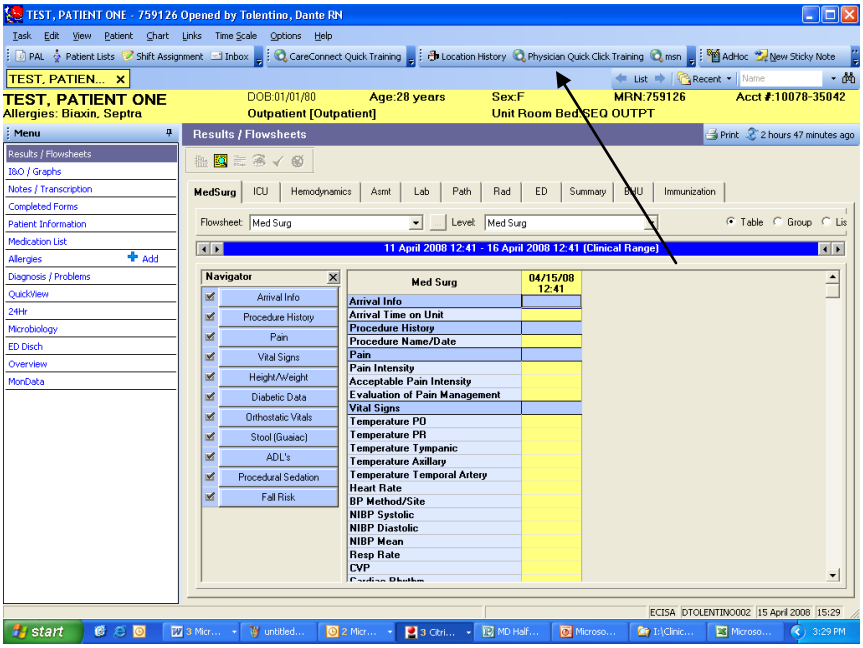
RECOMMENDED LESSONS FROM POWERCHART ONLINE TUTORIALS

To access online training, log in to CIS PowerChart and click "CareConnect Quick Training" icon from the toolbar.



This will take you to the Powerchart Online Tutorials.
Follow instructions or select modules you want to complete or review.

NOTES:

Developed for Sequoia Hospital
Contact your Clinical Informatics Team if you have any questions/suggestions
Anthony Tolentino, RN x5661 or Brent Kawaye, RN x6815
September 2011